CHAPTER V

Pregnant Women and Mothers

A. Introduction

Healthy babies are most often born to women who were healthy prior to conception, wanted to become pregnant, do not smoke or drink, live in a supportive environment, obtained early prenatal care, and have adequate resources to support their physical, material, and emotional health. Medical conditions, poor health behaviors, and negative environmental conditions can be identified, treated, and/or eliminated prior to conception to improve the health of the woman as well as decrease the likelihood of a poor birth outcome.

B. Characteristics of Women in Idaho

The distribution of race and ethnicity for women ages 15-44 mirrors the overall State demographic distribution. Non-Hispanic Whites account for 87.1 percent of the population, followed by Hispanic women at 9.3 percent. There are a small number of Native American, Asian, and Black women living in Idaho.

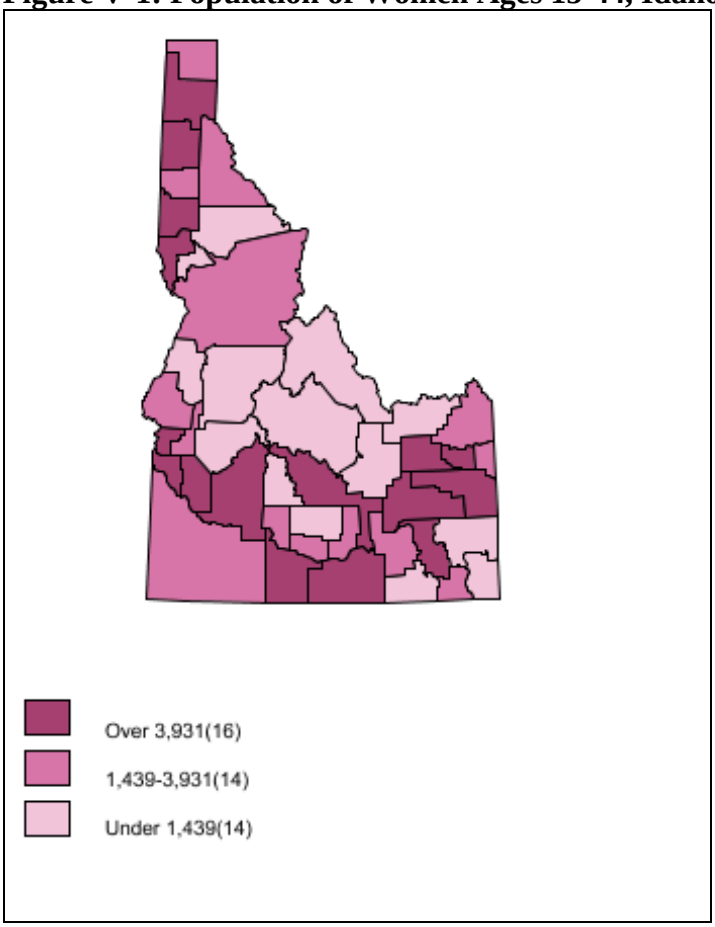
Table V-1.
Population of Women Ages 15-44 by Race or Ethnicity, Idaho, 2002

	Percent	Count
Hispanic	9.3	26,288
White	87.1	247,376
Black	0.5	1,430
Native American	1.5	4,384
Asian	1.6	4,640
Total	100	284,818

Source: March of Dimes 2005a (analysis of US Bureau of the Census. Population estimates for are projected from the 2000 Census based on bridged race categories, released by the National Center for Health Statistics.)

The women of childbearing age are concentrated in a few urban counties; given the rural and frontier nature of Idaho, there are 14 counties that have fewer than 1,439 women ages 15-44.

Figure V-1: Population of Women Ages 15-44, Idaho, 2002



Source: March of Dimes 2005b

The distribution by age among those 15-44 shows that almost 20 percent are teenagers.

Table V-2
Population of Women 15-44 by Age, Idaho, 2002

	Percent	Count
15-19	18.7	53,240
20-29	32.7	93,043
30-39	31	87,940
40-44	17.6	49,895
Total	100	284,818

Source: March of Dimes 2005b (analysis of US Bureau of the Census. Population estimates for are projected from the 2000 Census based on bridged race categories, released by the National Center for Health Statistics.)

Finally, 15.3 percent of Idaho women ages 15-44 have incomes below the 100 percent FPL. This is slightly more than the US average of 13.5 percent.

Table V-3. Women Ages 15-44 Below FPL, Idaho and U.S., 2000-2002 Average		
	Idaho (Percent)	**U.S. (Percent)**
Women 15-44	15.3	13.5

Source: March of Dimes. (2005c.)

Within this demographic context, the rest of the section explores women's health status and their access and utilization of health and social services.

C. Pregnant Women Outcomes Examined

Three outcomes have been selected for in-depth examination for the Idaho Pregnant Women population. Achieving these outcomes will help to ensure that women are healthy and able to care for themselves and their families.

Table V-4. Idaho Pregnant Women Outcomes
Women of childbearing age use ongoing preventive and primary care appropriately.
Pregnant women use early and adequate prenatal care.
Pregnant women use as appropriate the full range of enabling and support services to promote a positive pregnancy outcome.

1. Women of childbearing age use ongoing preventive and primary care appropriately.

> *"I use doctors for my children but do not get medical care myself."*
>
> *Migrant Head Start Staff*

Access to comprehensive, quality health services is an essential component of the health care system. To be accessible, services must be affordable, available, and within a reasonable travel distance. Also important is the quality and continuity of care available. This requires qualified staff able to provide a constellation of services that are delivered with respect and confidentiality.

a. Health Insurance

While there are a number of factors that influence health utilization, arguably none is more important in the United States than health insurance. When women are uninsured, they are more likely to postpone important preventive services such as Pap tests and go without filling prescriptions than their insured counterparts (Kaiser 2001).

The Kaiser Family Foundation describes Idaho's proportion of uninsured women as higher than the national average (20.1 percent to 17.7 percent). Although there is a larger proportion of low

income women in Idaho, compared to the United States, their rate of uninsured is about the same (see tables below).

Table V-5.
Health Insurance Enrollment of Women Ages 18 to 64, 2001-2002

	Idaho		US	
	All Women (Ages 18-64)	**Low-income* Women (Ages 18-64)**	**All Women (Ages 18-64)**	**Low-income Women (Ages 18-64)**
Estimated Number of Women (Thousands)	401	144 (35.8% of Total)	90,394	29,477 (32.6% of Total)
Percent with Private/Other**	71.3	43	73.7	42.6
Percent Medicaid	8.5	20.1	8.6	22.3
Percent Uninsured	20.1	36.9	17.7	35.2

*Low income is defined as <200% of poverty, or $30,040 for a family of 3 in 2002.

**Private/Other category includes: employer-based coverage, other private insurance, and other public insurance, such as Medicare and military-related coverage.
Source: The Kaiser Family Foundation. (2005a). State level figures based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates using pooled March 2002 and 2003 Current Population Surveys. U.S total based on March 2003 Current Population Survey.

While the Kaiser data offer one estimate of the prevalence of the uninsured, the Idaho PRATS, a self-report mailed survey to women 3-12 months postpartum, reports for 2001 a much larger proportion of women without health insurance just before pregnancy.[1]

- More than 1 in 3 Idaho resident adult mothers (36.4 percent) reported that they did not have health insurance at the time just before pregnancy.
- The lower-income (<$15,000) and Hispanic populations were more likely to lack insurance compared with mothers who have higher household incomes and/or are non-Hispanic Whites (IDHW, 2005a).

b. Health Insurance for Pregnant Women

Lack of health insurance precludes many pregnant women from getting the prenatal care they need. In 2001, approximately 45 percent of women who reported not obtaining prenatal care as early as desired indicated that it was because they did not have enough money or insurance to pay for the visits (28.1 percent) or did not have a Medicaid card (17.0 percent) (IDHW, 2005a).

[1] The PRATS data is a valuable source of information about pregnancy health and has been utilized throughout this needs assessment. However, like other data sources, PRATS data has limitations. With self-report surveys, there is a potential for under- or overreporting. As importantly, the PRATS survey collects data 3-12 months postpartum, and some questions ask the respondent to remember events or behaviors up to 12 months before they were pregnant. Therefore, some mothers may be asked to remember events that happened 33 months earlier. Mothers who respond to the survey when their infant is younger may recall events more accurately than mothers who respond when their infant is older.

Pregnant women who fall under 133 percent of the Federal poverty guidelines can qualify for Idaho Medicaid's Pregnant Women and Children (PWC) program (also known as Low Income Pregnant Women Medical Assistance). In 2001, approximately 40 percent of Idaho resident adult mothers reported applying for Medicaid coverage during their pregnancy (IDHW, 2005a). Of these women, 16.2 percent reported being told they were not eligible for the program. Hispanic populations were more likely to report they were told they were ineligible for Medicaid services (34.2 percent) than non-Hispanic mothers (12.7 percent). Mothers aged 35 and older reported being told they were ineligible for Medicaid services (36.0 percent) more than any other age group (IDHW, 2005a).

The reasons cited for ineligibility require further examination. Hispanic focus group participants reported general confusion on residency requirements for Medicaid. While the Medicaid application states that a Resident Alien Card (if not a U.S. citizen) or other residency documents are required, one woman noted that undocumented pregnant women in Idaho cannot qualify for Medicaid to cover prenatal care expenses, only delivery. It was also stated that the State wanted to see an actual citizen card, not just clearance papers from immigration. The forthcoming PRATS 2002 data further examines the reasons women were told they were ineligible, and that information will assist the State in understanding issues related to misinformation or miscommunication about policy requirements.

Lack of adequate health insurance not only prevents women from receiving the prenatal care they need; it may also influence their decision as to where to deliver their infants. Focus group participants and key informants described the cost of hospital care as a major factor in choosing a home birth. Hospital delivery is approximately $5,000, while in comparison the cost of lay midwife services for prenatal and delivery care is approximately $1,000.

It is also interesting to note that in a study conducted by the Urban Institute and the Center for Studying Health System Change, to assess changes in Medicaid fees, Idaho reported only a 3.8 cumulative percentage change in Medicaid fees for obstetric care over the years 1998-2003. This compares to a U.S. cumulative percentage change of 10.2 percent for obstetric care (Zuckerman, 2004). The adequacy of reimbursement can have a direct effect on the ability of a provider to offer services to those with Medicaid insurance.

c. Medicaid Guidelines

There are two major Medicaid programs in Idaho:

1. Title XIX AFDC-related coverage groups (Income is based on the AFDC Payment Standard in 1996). This includes the full package of Medicaid benefits.

2. Title XIX Medicaid coverage groups of Qualified Pregnant Women or Low Income Families with Children (Income is up to 133 percent of the Federal poverty guidelines). This includes pregnancy-related services only.

Both of these coverage groups are federally required. The Qualified Pregnant Women or Low Income Families with Children coverage group is known in Idaho as the Pregnant Women and Children program (PWC). Idaho is one of 13 states that chose not to expand coverage beyond the federal requirement (133 percent of poverty) for pregnant women.

PWC Coverage is limited to pregnancy-related and postpartum services. These include pregnancy testing, vitamins, lab and x-ray services, dental care, outpatient mental health services, OB/GYN visits, labor and delivery, and any other Medicaid services that the woman's doctor feels are medically necessary to ensure a positive outcome for the mother and baby. Nutrition, breastfeeding, and social support services are also included in the package of benefits. This package of services is not well understood or utilized by key-informant prenatal care providers. In particular, some providers reported that mental health services are not allowable services, even if prenatal or postpartum depression is indicated. Further investigation into the number of auxiliary service claims would be useful to understand better the breadth of care utilized.

PWC medical assistance coverage extends through the 60-day postpartum period if the woman applied for medical assistance while pregnant and was receiving medical assistance when the child was born. An individual who applies for PWC medical assistance after the child is born is not eligible for the 60-day postpartum period. In other words, unless women received prenatal care or were enrolled in health insurance during pregnancy, they are not able to receive any postpartum service. For these women, services that treat maternal and postpartum complications or screen for postpartum depression cannot not be provided.

A pregnant woman can obtain limited ambulatory prenatal care as a presumptively eligible (PE) pregnant woman through the end of the month after the month in which the provider completes the PE determination. PE coverage is designed to provide limited prenatal care during the time between the pregnancy diagnosis and the eligibility determination. A qualified PE provider, such as a District Health Office (DHO), accepts written requests for these services and completes the eligibility determination. The Central District Health Department is one provider who both is a PE provider and bills Medicaid for an abbreviated version of the high-risk PWC services. They know of no one else in the State who is performing such services. The number of geographic distribution of qualified PE providers is not available for this assessment.

The Idaho Medicaid Policy Team described how Medicaid supports enhanced services for high-risk pregnancies (key informant interview, October 2004). Health providers make the clinical determination whether the pregnant woman is experiencing a high-risk pregnancy. If so, she is able to receive two social-service visits, an additional two nutrition visits, two nursing visits, and a once-per-month risk-reduction visit. Guidelines are not Web posted or available through other established information venues, nor are they included in the provider or family manual. Broader awareness and utilization of this important resource could have very beneficial effects for the outcomes of high-risk pregnancies. Further investigation is also required to better describe the number of women who use these high-risk services and their pregnancy outcomes.

As of January 2005, the Medicaid Care Management Team instituted a new high-risk prenatal identification system and followup. The program integrates the Qualis Utilization Management

(UM) and Case Management (CM) services for the prenatal population. The UM service identifies pregnant women who have been in the hospital longer than 3 days, and for such patients, the CM service works closely with hospital discharge planners and in-home or community supports to move the patient out of the hospital and into her home. The Case Manager provides support by telephone, assisting the pregnant woman to get the services that she needs, and solving how to access outpatient, ongoing prenatal care. A pregnant woman can also be included in these case management services if referred by her doctor. This new initiative will be described in the January 2005 Medicaid newsletter and a letter will be sent to every provider who submitted an OB claim in the last year. This is a promising initiative that will better link pregnant women to necessary health services. There seems to be a disconnect between the Medicaid CM staff interviewed and the Medicaid Policy Team regarding this service as the case managers interviewed were not aware of the additional services high-risk women can access.

Further exploration is required to understand if women are aware of Medicaid eligibility guidelines and services available. To obtain prenatal care in the first trimester of pregnancy, the pregnant woman needs to begin the Medicaid application process as soon as possible. Currently, Medicaid does not fund any outreach program for eligible pregnant women. Furthermore, while the Medicaid application for assistance is easy to understand, there are no statewide materials that describe the benefits and rules for the PWC program to pregnant women who are low literacy. Materials in Spanish are available.

Another important Medicaid program is the Medicaid waiver for family planning as it affects women's access to care. The waiver serves to extend eligibility for Medicaid-covered family planning services to individuals who would otherwise not be eligible for such care. An evaluation commissioned by the Federal CMS documented that not only did these expanded programs provide critical contraceptive services as well as tests for cervical cancer, sexually transmitted diseases, and HIV for those who would otherwise not be eligible for such care, but they actually *saved* money for both the State and the Federal governments. Currently, there are 16 states that have a Medicaid family planning waiver. Idaho is not one of them (Gold, 2004).

d. State Policies and Practices for Private Insurance

The Henry J. Kaiser Family Foundation identifies specific State policies that include regulations to promote access to women's health services. The table below describes women's health services that some States regulate as mandated benefits of private insurers. Of the specific possible mandated benefits highlighted by Kaiser, Idaho mandates direct access to OB/GYN physicians and permits them to act as primary care providers.

Table V-6
Idaho Mandated Benefits, Private Insurers

	Idaho	U.S.
Mandates Contraceptive Coverage?	No	21 Yes
Mandates Coverage of Mastectomy Stay?	No	20 Yes

Table V-6 Idaho Mandated Benefits, Private Insurers		
	Idaho	**U.S.**
Mandates Reconstructive Surgery After Mastectomy?	No	39 Yes
Mandates Osteoporosis Screening?	No	13 Yes
Mandates Chlamydia Screening?	No	3 Yes
Mandates Infertility Diagnosis and Treatment?	No	14 Yes
Mandates Direct Access to OB/GYNs?	Yes	40 Yes
Mandates that OB/GYNs can be Primary Care Providers?	Yes	17 Yes

Source: The Kaiser Family Foundation, 2005b.

e. Family Planning

It is important to examine access to and utilization of family planning services when assessing women's health. Not only is family planning utilization an indication that women are accessing preventive services; it also helps women and their partners to realize their family size goals and the timing of those goals. Furthermore, for every public dollar spent on family planning services, $3 are saved in Medicaid costs for pregnancy-related and newborn care (Guttmacher, 2000).

- ***Number and Distribution of Family Planning Clinics in Idaho***

In 2003, there were 69 publicly supported family planning clinics in Idaho; 39 are administered by health departments, 5 by hospitals, 1 by Planned Parenthood, 18 by CHCs, and 6 by other types of agencies (Guttmacher, 2004).

Funding for Title X Supported Clinics, the Federal grant which provides for a range of reproductive health services for women and men who are at or below the poverty level, has increased slightly over the last 3 years. The State does not supplement Federal dollars. Of the 69 family planning clinics, approximately 40 are supported with Title X dollars. The DHOs administer most of these 40 clinics. Due to almost level funding, DHOs report that they are allocating resources from other projects to meet demand.

- ***Women Receiving Family Planning Services Prior to Pregnancy***

Description of Need

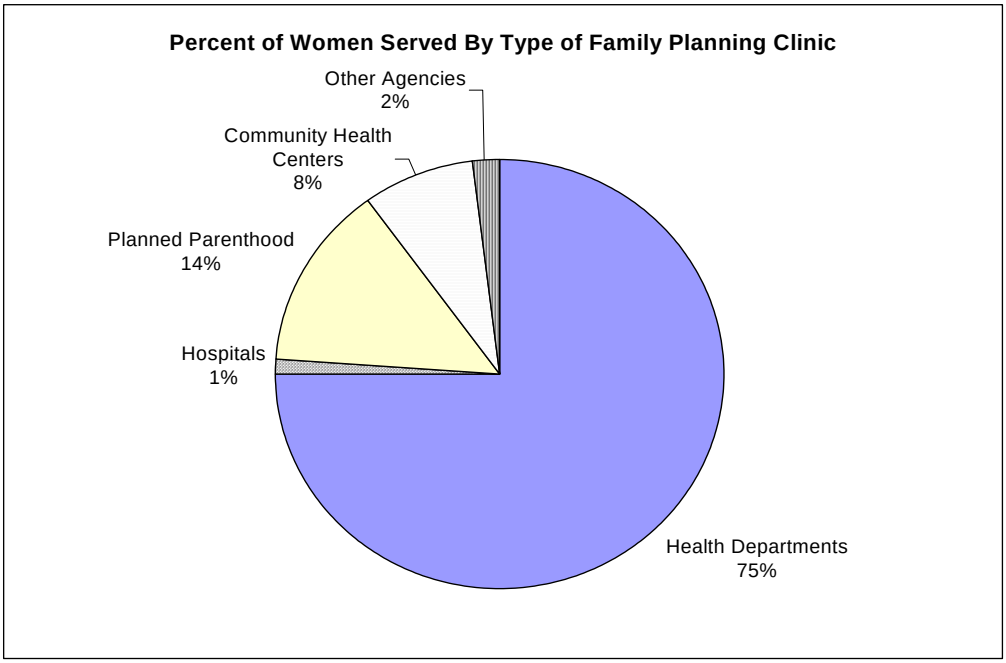
The Guttmacher Institute attempts to quantify the number of Idahoan women in need of contraceptive services and supplies (see http://www.guttmacher.org/pubs/win/index.html). Women are defined as "in need of contraceptive services and supplies" during a given year if they are aged 13-44 and meet three criteria: (1) they are sexually active, that is, they have ever had intercourse; (2) they are fecund, meaning that neither they nor their partner have been contraceptively sterilized and they do not believe that they are infecund for any other reason; and (3) during at least part of the year, they are neither intentionally pregnant nor trying to become pregnant.

According to Guttmacher, in 2002, there were 140,820 women in need of contraceptive services and supplies in Idaho. Of these, 80,360 women—including 22,380 teenagers—are in need of publicly supported contraceptive services (Guttmacher, 2004).

Service Utilization

In 2001, family planning clinics in Idaho served 41,720 women, including 12,890 teenagers. Seventy-five (75) percent are served by health departments, 1 percent by hospitals, 14 percent by Planned Parenthood, 8 percent by community health centers, and 2 percent by other types of agencies. Title X-supported clinics in Idaho served the majority of these women (37,090 out of 41,720). Of the total number of women served in Title X-supported clinics in Idaho, 11,300 are teenagers (see Figure V-2 below).

Figure V-2: Percent of Women Served by Type of Family Planning Clinic, 2001



Source: *Number of publicly funded family planning clinics and female clients served by type of provider, 2001*: AGI, special tabulations of AGI's 2001 census of all publicly funded family planning clinics, methodology and national data reported in Frost J, Frohwirth, L and Purcell, A, "The availability and use of publicly funded family planning clinics: U.S. Trends, 1994-2001," forthcoming in *Perspectives on Sexual and Reproductive Health*, 2004

In 2003, The Idaho Reproductive Health Program (Title X) provided education, counseling, and health services to more than 38,500 Idahoans.

In comparison to the United States average, Idaho has been successful in reaching its population in need of Title X services. In the United States, approximately 40 percent of the women in need of public services received them, while Idaho has served 50 percent of its target population (Table V-7).

Table V-7 Total Number of Women in Need of Contraceptive Services and Supplies, 2002; Number Served by Publicly Funded Clinics, 2001; and the Ratio* of Women Served to Women in Need of Public Services				
	Women in Need of Contraceptive Services and Supplies, 2002		Women Served at Publicly Funded Clinics, 2001	Ratio of Women Served to Women in Need of Public Services
	Total	In Need of Public Services**		
US	34,241,690	16,776,730	6,663,570	40%
Idaho	145,110	83,120	41,720	50%

*These ratios estimate the need that is met by clinics. They exclude women who receive Medicaid-covered services from private providers and users of nonprescription methods who have not visited a contraceptive service provider. In addition, they include some nonpoor women who are served by publicly funded clinics even though they do not fit the income definition of women in need.
**Women in need of public services include adult women below 250 percent of the FPL plus all women younger than 20 who are in need of contraceptive services and supplies.
Source: Guttmacher, 2004

Although these numbers reflect the successful outreach and accessibility of current services, there may still be pockets of the Idaho community that are not well served. While Title X is reaching half the eligible population, it is unknown if the other 50 percent are receiving services. Latina women, in particular, are reported to have little access to family planning information. According to IPCA's focus group report, respondents stated that the high Latina teen pregnancy rate is due to the lack of education and family planning resources (Hakes, 2003).

- ***Prevention of Unintended Pregnancies***

The objectives set out by Healthy People 2010—to increase the percentage of intended pregnancies to 70 percent (Objective 9-1) and to increase the proportion of females at risk for unintended pregnancy (and their partners) who use contraception to 100 percent (Objective 9-3)—underscore the importance of preventing unintended pregnancies.

According to the Federal Office of Population Affairs, Office of Family Planning, with an unintended pregnancy the mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all (Kost, 1998a). She is less likely to breastfeed (Dye, 1997) and more likely to expose the fetus to harmful substances, such as tobacco or alcohol (Brown, 1995). The child of such a pregnancy is at greater risk of LBW, dying in its first year, being abused, and not receiving sufficient resources for healthy development (Kost, 1998b). A disproportionate share of the women bearing children whose conception was unintended are unmarried or at either end of the reproductive age span—factors that, in themselves, carry increased medical and social burdens for children and their parents. Pregnancy begun without some degree of planning often prevents individual women and men from participating in preconception risk identification and management.

The consequences of unintended pregnancy are profound; however, it is very difficult to measure the intendedness because of how questions about "intendedness" are asked and whether point-in-time data can reflect the intendedness of the pregnancy accurately. In 2003 in Idaho, 1,779 women who went to a DHO for services reported not using a contraceptive method because they were currently pregnant. Of these, 1,105 (62.1 percent) stated the pregnancy was unplanned while 674 (37.9 percent) stated the pregnancy was planned (Family Planning Program, 2004). However, 3 months postpartum, only 37.5 percent of women reported their pregnancy was unintended at the time of conception (IDHW, 2005a).

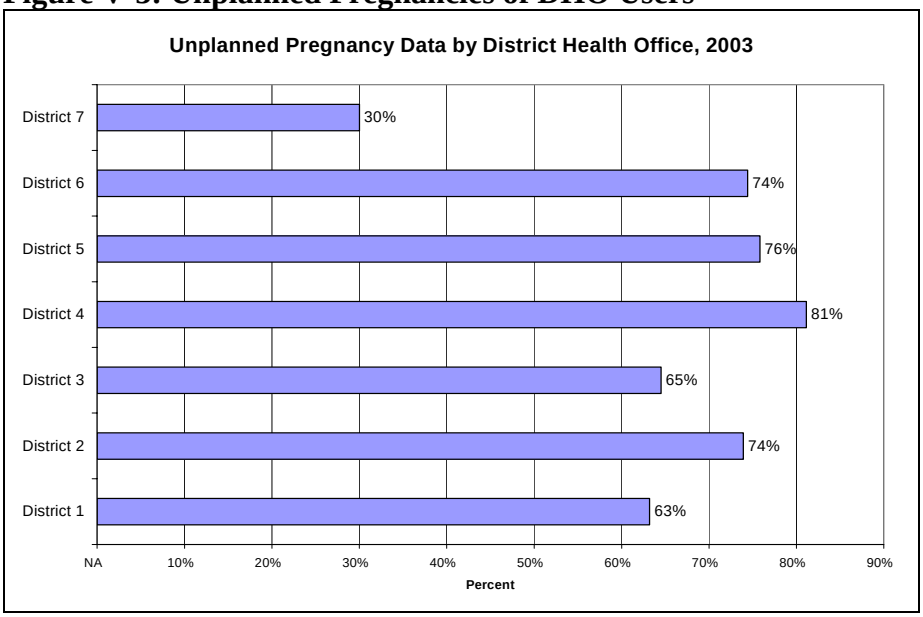
Most likely, there are several factors that contribute to these data differences. One is that the PRATS data is population based whereas the DHO is service-based information. Another factor is the point in time when the question is asked (i.e., when one first found out about being pregnant versus 3-12 months postpartum). A third factor is how the question was asked of the respondent. The words used may vary substantially among the DHO providers compared with the written words used in the PRATS survey.

Given the ambiguity of using intendedness of pregnancy as a predictor of birth outcomes, this assessment will examine unintended pregnancies as a measure of access and utilization of contraceptives.

In 1999, of the 17 States that participated in the PRAMS study (which is a retrospective study similar to the Idaho PRATS study), the prevalence of unintended pregnancy among women who had live births ranged from 33.7 percent (Utah) to 52.0 percent (Louisiana) (Beck, 2003). Idaho falls at the lower end within that continuum, with approximately one-third (37.5 percent) of Idaho resident adult mothers indicating that their pregnancy was unintended at the time of conception in 2001 (IDHW, 2005a).

Data from the DHOs reveal variations among age, ethnicity, and district. District 4 reported that 81 percent of the women who came to their clinic did not plan their pregnancy, while only 30 percent of women in District 7 reported the same (Figure V-3).

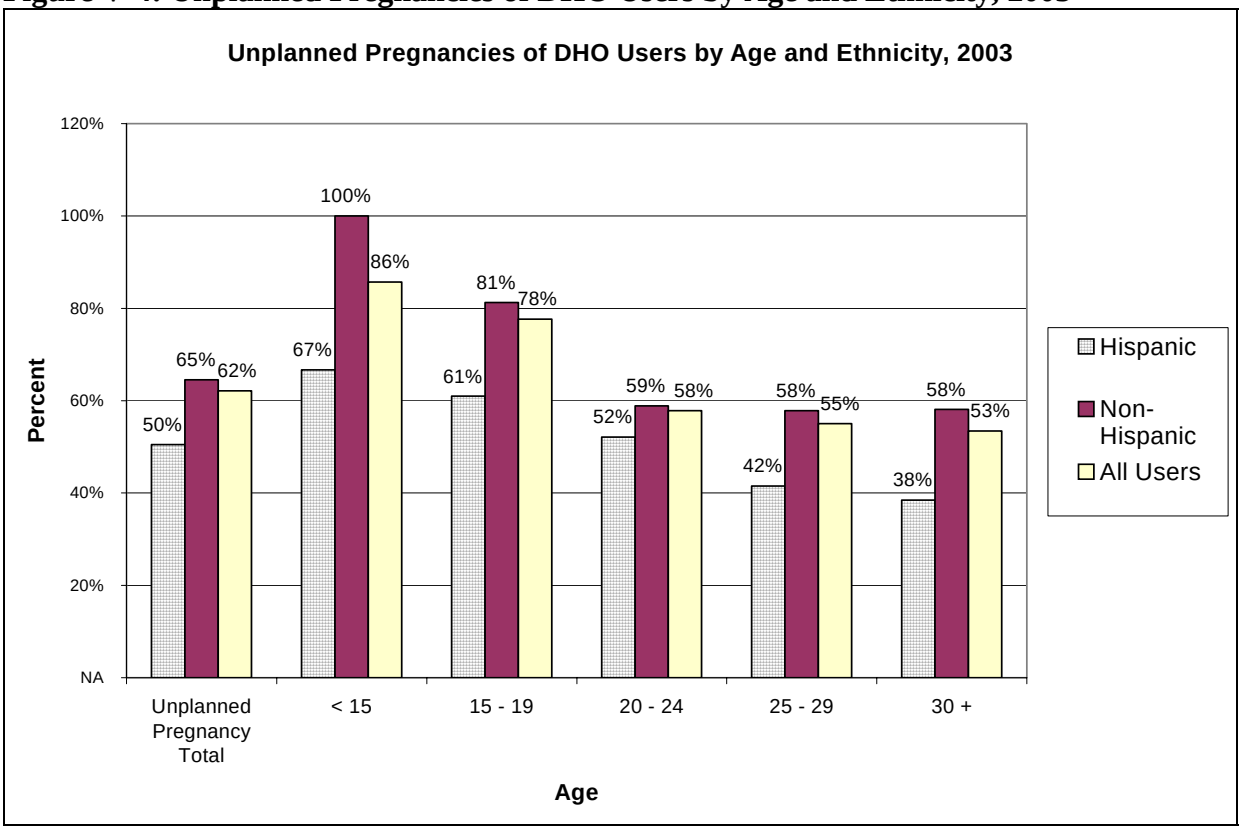
Figure V-3: Unplanned Pregnancies of DHO Users



Source: Family Planning Program, 2004

There were similar variations in planned pregnancies among age and ethnicity. Sixty-five (65) percent of non-Hispanic women reported the pregnancy to be unplanned as compared to 50 percent of Hispanic women. The difference by ethnicity was apparent for each of the age categories. As would be expected, there were less planned pregnancies among teenagers compared to women ages 20 and older. However, the data for Hispanic teens are worth noting. Approximately 33 percent of Hispanic teens under the age of 15 and 39 percent of Hispanic teens ages 15-19 reported that their pregnancy was planned.

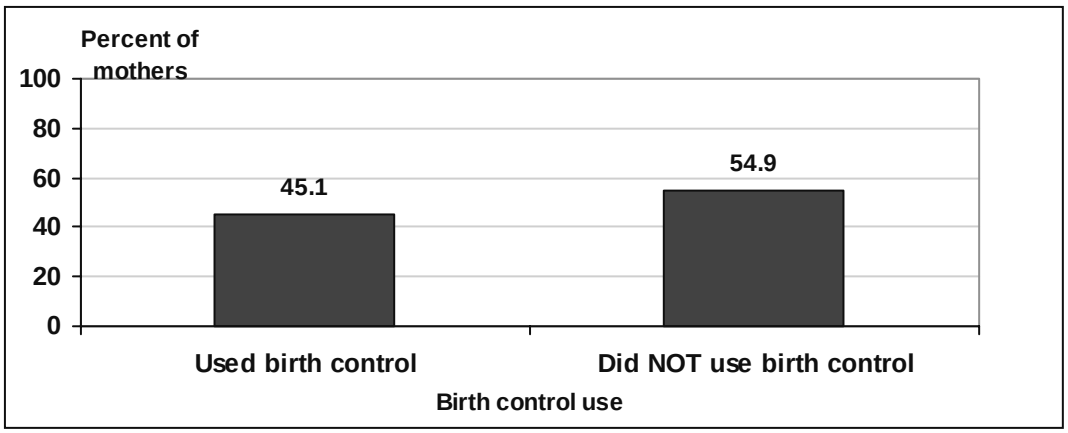
Figure V-4: Unplanned Pregnancies of DHO Users by Age and Ethnicity, 2003



Source: Family Planning Program, 2004

National PRAMS Data illustrated that in 1999, the prevalence of any type of birth control use at time of pregnancy among women who reported that their pregnancy was unintended ranged from 33.2 percent (Ohio) to 45.6 percent (Maine) (Beck, 2003). Idaho falls at the higher end of this range, with 45.1 percent stating they were using birth control at time of pregnancy (IDHW, 2005a) (Figure V-5).

Figure V-5: Birth Control Utilization at Time of Conception Among Idahoan Mothers Not Trying to Get Pregnant in 2001



Source: IDHW, 2005a

- ***Abortions***

Induced abortion is another consequence of unintended pregnancy.

In Idaho in 2000, 27,460 of the 278,010 women of childbearing age became pregnant. Of these pregnancies, 74 percent resulted in live births, 10 percent in abortions, and 16 percent in miscarriages. The percentage of pregnancies resulting in an abortion in Idaho is substantially lower than the national average (Guttmacher, 2004).

The estimated pregnancy rate in 2000 among Idaho's 15- to 19-year-old women was 62 per 1,000. The State ranks 37th nationally. Of those pregnancies, 69 percent result in a live birth and 16 percent result in a miscarriage (Guttmacher, 2004).

The table below describes the number of induced abortions, the rate per 1,000 females by age bracket, and the ratio per 1,000 live births by age bracket. Across each of the categories, Idaho reports a lower rate and ratio of abortions compared to the United States.

Table V-8.
Induced Abortions in the United States and Idaho

	Induced Abortions	Ratio per 1,000 Live Births	Rate per 1,000 Females Aged 10-14	Rate per 1,000 Females Aged 15-19	Rate per 1,000 Females Aged 15-44
US 2000	850,293	246	2.0	17	16
Idaho 2002 (Residence)	1,493	71	0.2	6.1	5.3

Source: IDHW, 2004a (analysis of: "Abortion Surveillance - United States, 2000," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, Vol. 52/No. SS-12, November 23, 2003)

The relatively low rate of abortions in Idaho may be due to a number of reasons. One is contraceptive use, as this is a key predictor of women's recourse to abortion. The group of American women who are at risk of experiencing an unintended pregnancy but are not using contraceptives account for almost half of all abortions—46 percent in 2000 (Guttmacher, 2004). Given that Idaho has been successful in reaching a larger proportion of its population with family planning services than the U.S. average, the Title X Program may be playing a pivotal role in avoiding unintended pregnancies. It is estimated that Idaho's publicly funded family planning clinics help women avoid 9,500 unintended pregnancies each year (Guttmacher, 2004).

Another possible reason for the low abortion rate may be due to the lack of access to legal abortion services. In 2000, there were seven abortion providers in Idaho. Ninety-three (93) percent of Idaho counties had no abortion provider, and 67 percent of Idaho women lived in these counties. In the Western U.S. census region, where Idaho is located, 19 percent of women having abortions traveled at least 50 miles and 6 percent traveled more than 100 miles to obtain this service (Finer, 2003).

Other reasons for the low rates may be the regulatory requirements placed on women seeking abortion or that many women travel out of State to have abortions and the abortions go unreported in Idaho. This service may be obtained out of State when the barriers to obtaining an abortion—such as gestational limits or expense—are lower in neighboring States.

f. Nutrition

Making healthy choices about nutrition contributes substantially to preventing illness and premature death (Frazao, 1999). Approximately 74 percent of the 2002 Idaho Behavioral Risk Factor Surveillance System (BRFSS) female respondents did not consume the recommended five servings of fruit and vegetables each day. The youngest age group (18-24) were the least likely to consume 5 or more servings a day (14.9 percent), and the oldest age group (65+) were most likely (38.6 percent) (IDHW, 2003a).

Vitamin and mineral supplement use is of particular interest for the health of women. There are specific circumstances during a woman's life cycle which are associated with special vitamin and mineral supplement needs (e.g., prior to conception, during pregnancy, and when at risk for certain health conditions such as osteoporosis). In 2001, approximately half (47.3 percent) of Idaho resident adult mothers reported taking a vitamin supplement during the 3 months before becoming pregnant. Almost all mothers (92.7 percent) reported taking vitamin supplements during pregnancy (IDHW, 2005a). Women were more likely to take vitamin supplements during the 3 months before becoming pregnant if the pregnancy was intended than if the pregnancy was unintended. Women were also more likely to take vitamin supplements during pregnancy if they reported being given information about the importance of taking vitamin supplements prenatally.

g. Physical Activity

Similar to healthy food choices, regular physical activity is essential for maintaining a healthy body, enhancing psychological well-being, and preventing a variety of chronic diseases and premature death. It is a concrete step Idaho women can take to keep themselves healthy. Unfortunately, physical inactivity is a significant problem among U.S. adults, contributing to a host of health risk factors and health conditions including obesity, hypertension, heart disease, diabetes, and cancer.

Nationally, men are more likely than women to participate in regular physical activity, and this is also true for Idaho. In 2003, females were significantly more likely to not participate in leisure time physical activity (20.1 percent) than males (16.5 percent). Rates decreased for both men and women with advancing age; 69.2 percent of women aged 65 and older reported being physically active compared to 84.4 percent of females aged 18-24 (IDHW, 2004b).

h. Overweight and Obesity

Overweight and obesity are linked to chronic conditions such as high blood pressure, heart disease, diabetes, and stroke. An expert panel convened by the National Institutes of Health used

height and weight measurements to define overweight as a Body Mass Index (BMI) of 25 kg/m^2 or greater and obesity as a BMI of 30 kg/m^2 or greater.

Using these definitions, according to the 2002 BRFSS, Idahoan adult females were less likely to be overweight than males (48.7 percent versus 65.7 percent). The Healthy People 2010 goal is to have 60 percent of adults at a healthy weight. Approximately 51 percent of Idahoan women are at a healthy weight. In 2002, in Idaho, women who were aged 18-24 were less likely to be overweight or obese, while those ages 45-54 and 55-64 were more likely to be overweight or obese. Almost half of Idaho women are either overweight or obese (IDHW, 2003a). The Idaho Diabetes Prevention and Control Program has launched programs to provide support to health care providers and their overweight patients. They have created publications that offer information and resources to physicians and other health care providers addressing the challenges of overweight and obese patients with and without diabetes in Idaho. Additionally, the Idaho Physical Activity and Nutrition Program has been launched to address obesity and other health related conditions caused by physical inactivity and poor eating habits.

i. Breast and Cervical Cancer

Important indicators of women's access to and utilization of primary and preventive services are the breast and cervical cancer screening rates and the proportion of cancer cases that are diagnosed in their early stages. This needs assessment will focus on screening and early stage diagnosis rather than cancer incidence and mortality.

The Cancer Registry of Idaho, along with the Women's Health Check, analyzed the breast and cervical cancer incidence, mortality, and screening data in Idaho and compared it to the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute.

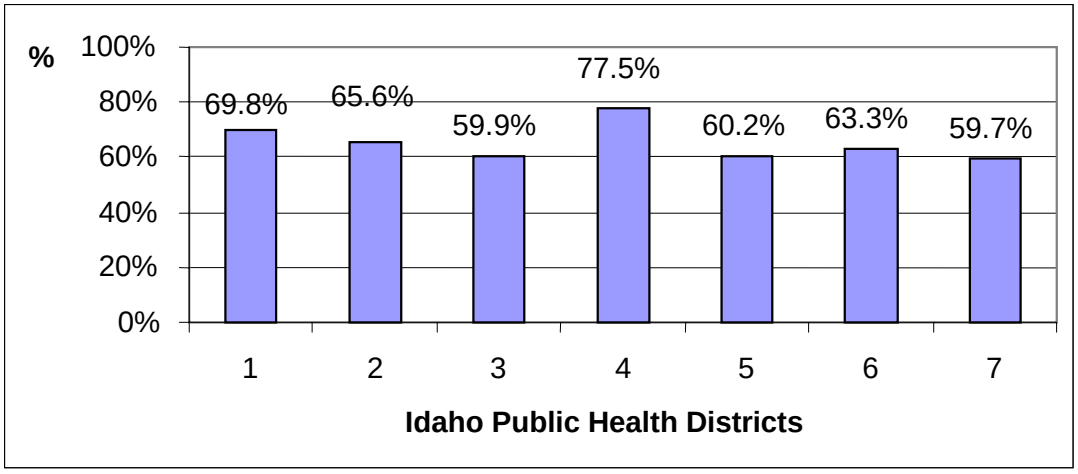
While many of the incidence and mortality data are similar to or lower than the national trends, screening data from the BRFSS coupled with stage distribution and stage-specific incidence rates strongly suggest that racial or ethnic discrepancies exist in Idaho in terms of diagnosing breast cancers early among younger women (aged less than approximately 55) (Johnson, 2004).

- ***Breast Cancer Screening and Staging***

The earlier breast cancer is detected, the less likely a woman will need highly invasive and uncomfortable treatments, and the more likely she will survive the disease. It is important to detect the disease in its earliest stages through screening mammography, clinical breast examination, and for women 20 years of age and older, breast self-examination. The Healthy People 2010 Objective 3-13 reflects this importance: to increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years to 70 percent.

In 2002, 67.0 percent of Idaho women aged 40 years and older had received a mammogram within the previous 2 years. However, breast cancer screening rates vary among Idaho's public health districts, ranging from a low of 59.7 percent in Health District Seven to 77.5 percent in the Central Health District (Johnson, 2004).

Figure V-6: Mammogram During Past 2 Years, 2002, Women Aged 40 and Older (BRFSS)



Source: Johnson, 2004 (analysis of BRFSS, 2002)

Breast cancer staging is the process of describing the extent of the disease or the spread of the cancer from the site of origin. Again, the earlier the diagnosis, the better the chance the woman will survive the disease. In Idaho, Hispanic women and uninsured women were more likely to be diagnosed with late-stage breast cancer. As described below (Table V-9), in 1998-2002, 37 percent of Hispanic women and 30 percent of non-Hispanic women were diagnosed with late-stage breast cancer in Idaho. In SEER regions, 1996-2000, 34 percent of Hispanic women and 28 percent of non-Hispanic women were diagnosed with late-stage breast cancers (Johnson, 2004).

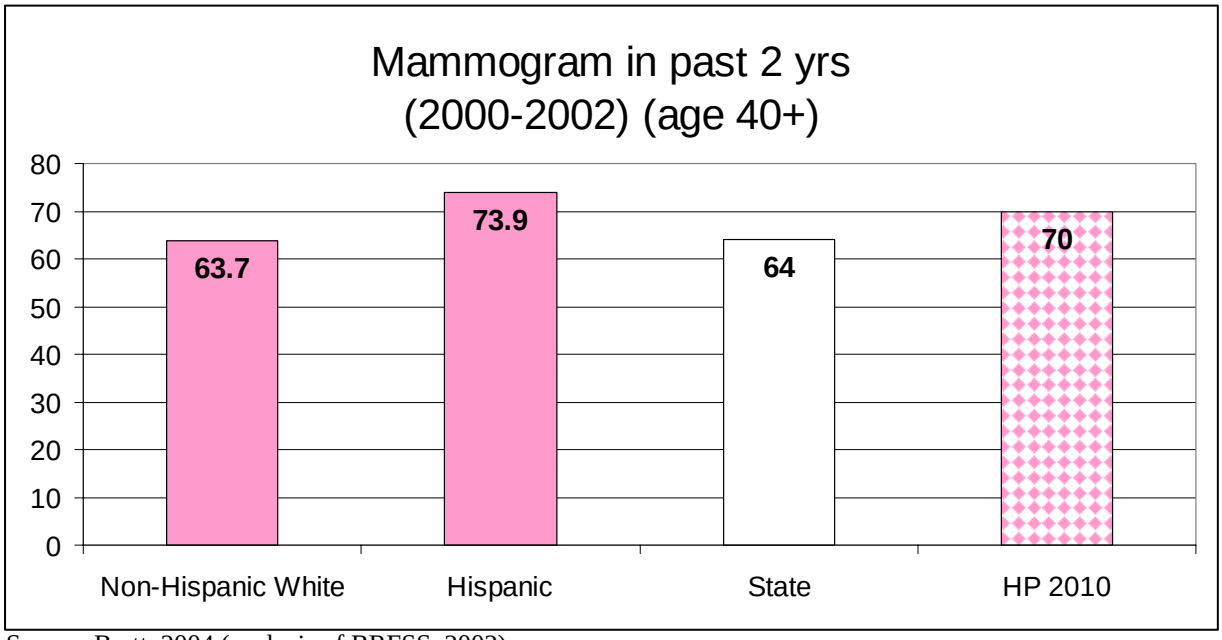
Table V-9.
Late-stage Breast Cancer Diagnosis

	Hispanic	Non-Hispanic
Idaho (Years 1998-2002)	37%	30%
SEER (Years 1996-2000)	34%	28%

Source: Johnson, 2004

As described by the report *Health Care Access Barriers by Idaho Latinos*, Latina women lack knowledge regarding the importance of preventative screenings, such as Pap smears and mammograms, and access to receive them (Hakes, 2003). Paradoxically, Hispanic females reported similar rates of screening to their white female counterparts (Figure V-7).

Figure V-7: Mammogram in Past 2 Years by Ethnicity, 2000-2002



Source: Brett, 2004 (analysis of BRFSS, 2002)

Women with Medicaid or uninsured women were significantly more likely to have late-stage diagnoses compared with women with private insurance or Medicare. Among Idaho female breast cancer cases under age 65, stage at diagnosis was statistically significantly related to insurance status ($p < 0.001$). For women aged 65 and older, over 90 percent have Medicare or private insurance, and about 25 percent of these cases have late-stage diagnoses.

- ***Cervical Cancer Screening (Pap Testing)***

Cervical cancer screening using the Pap test detects not only cancer but also precancerous lesions. Women should begin getting a Pap test with the start of sexual activity, but no later than at 18 years of age, and repeat the test at least every 3 years. Routine screening for cervical cancer can prevent many occurrences of this disease.

The Healthy People 2010 Objective is to increase the proportion of women who receive a Pap test to 90 percent. In 2002, 83.4 percent of Idahoan women reported receiving a pap test in the last 3 years (IDHW, 2003a). There was variation among districts, with 87.9 percent of females in District 4 receiving a Pap test in comparison to 78.1 percent in District 5. There are also significant differences by

- ***Age.*** Women aged 65 and older were significantly less likely to have received a Pap test in the last 3 years (62.7 percent).
- ***Income.*** Women with household incomes greater than $50,000 were significantly more likely to have had a Pap test in the last 3 years (91.0 percent). By comparison, those with incomes less than $15,000 were 4.4 times less likely to have had a Pap test (79.9 percent).

- ***Insurance Coverage.*** Females not having had a Pap test within the last 3 years were 2.3 times more likely than those receiving a Pap test to not have health care coverage.

Screening data from the BRFSS coupled with stage distributions strongly suggest that an age-related discrepancy exists in Idaho in terms of diagnosing cervical cancers late among older women (Johnson, 2004).

- ***Women's Health Check***

The Women's Health Check program is charged with improving the rate of breast and cervical screenings. It contracts with health providers to coordinate screening and diagnostic services for eligible women throughout Idaho. In addition to screening, the Women's Health Check Program partners with others to provide breast and cervical cancer education and outreach opportunities and clinical breast exam training for health care professionals. Over the last 3 years, the program has experienced a fifty percent increase in the number of screenings; however, it is anticipated that by 2005, program capacity will be reached.

Table V-10.
Women's Health Check, Number of Women Screened for Breast or Cervical Cancer

State Fiscal Year 7/1-6/30	Number of Unique Women Screened
2004	3003*
2003	2487
2002	2214
2001	2097

*Numbers are not finalized.
Source: Women's Health Check Program, 2004

It would be useful if future analyses included county (or health district)-specific age and ethnicity data to further explore the disparities described above.

j. Oral Health

According to self-reported BRFSS data, 44.6 percent of Idaho adults lacked dental insurance in 2003. There were significant differences by age, with 77.3 percent of those over age 65 without dental insurance (IDHW, 2004b). The BRFSS described how males were significantly more likely not to have visited a dentist in the previous 12 months (36.0 percent) than females (31.7 percent). Adults 65 and older were significantly less likely to have visited a dentist in the previous 12 months (40.4 percent) than those in younger age groups (IDHW, 2004b).

Over the last decade, there was very little change in the percentage of the adult population who had not received annual dental care by visiting a dentist. In 2003, 33.8 percent of adults had not visited a dentist within the previous 12 months. Health Districts 1 and 3 had significantly higher percentages of the adult population who did not visit the dentist in the previous 12 months (37.9

percent and 41.5 percent, respectively). Health Districts 4 (25.9 percent) and 7 (29.8 percent) had significantly lower percentages (IDHW, 2004b).

In pregnancy, there is an increased risk for certain oral diseases (e.g., gingivitis), and recent research suggests a potential association between maternal periodontal (gum) disease and risk for preterm delivery, which in turn increases the risk of having an LBW baby.

In 2001, women 3-12 months postpartum described their oral health practices during pregnancy (IDHW, 2005a):

- Sixty-six (66) percent of mothers reported that their prenatal health care providers did not tell them about the importance of getting regular dental care during their most recent pregnancy.
- Sixty-three (63) percent of mothers reported that they did not go to a dentist or dental clinic for routine dental care during their most recent pregnancy.
- Twenty-three (23) percent of mothers who did not get dental care during their most recent pregnancy reported that they did not feel getting dental care was important.

k. Mental Health

An assessment of women's health is not complete without an examination of the social, emotional, and environmental factors that contribute to her health and well-being. The issues of mental health, substance abuse, domestic violence, and their co-occurring interplay are often not included in health assessments. However, from a preventive, public health perspective, this holistic approach is essential.

- ***Mental Health and Well-being***

A woman's mental health is vital to her personal well-being, her ability to parent, and her ability to have positive family and interpersonal relationships. A continuum of mental health services includes promotion of mental wellness, prevention of mental health problems, and treatment of mental illness.

In the United States, nearly twice as many women (12.0 percent) as men (6.6 percent) are affected by a depressive disorder each year (Reiger, 1993). Depressive disorders include major depression, dysthymic disorder (a less severe but more chronic form of depression), and bipolar disorder (manic-depressive illness). In Idaho, the rate of death by suicide among women is much higher than it is nationally, at 6.2 per 100,000 in Idaho and 4.0 in the United States in 1999-2001 (Caiazza, 2004).

State mental health systems primarily focus on individuals with acute mental illnesses and creating a system to treat them. Most States use a variation of the American Psychiatric Association's DSM-IV to define their target population, usually categorized as having serious

mental illness (SMI) or severe and persistent mental illness (SPMI). Experts estimate that 5.4 percent of the U.S. population have SMI and 2.6 percent have SPMI.

Idaho's Mental Health Program targets individuals with SPMI, as defined by when a person has schizophrenia, schizoaffective disorder, major affective disorder, delusional disorder, or a borderline personality disorder; and that this psychiatric disorder is of sufficient severity to cause a disturbance in role performance or coping skills in at least two of these areas on either a continuous or an intermittent (at least once per year) basis: vocational or academic, financial, social or interpersonal, family, basic living skills, housing, community, or health.

Utilizing vital statistics information, the Department of Health and Welfare estimated that in 2002 there were approximately 1,200 individuals in Idaho with SPMI, an increase of almost 5 percent from 2000 to 2002 (Mental Health Program, 2004). SMI and SPMI are more clearly defined than mild-to-moderate feelings of anxiety, depression, and stress that, if left untreated, can have life-threatening consequences to the individual and her family. The Idaho Behavioral Risk Factor Surveillance System and the Idaho PRATS are data sources that provide some understanding of these mental health problems.

In 2003, 43.4 percent of females in Idaho reported poor mental health. This is in comparison to the national average of 38.3 percent. (Table V-11)

Table V-11.
Percent Reporting Poor Mental Health during the Past Thirty Days by Gender, 2003

	Idaho	US
Male	30.3	29.1
Female	43.4	38.3

Sources: The Kaiser Family Foundation, 2003.

In 2001, the Idaho Department of Health and Welfare conducted a study to take a more in-depth look at mental health among Idaho women of childbearing age. The results showed that 37.2 percent of women aged 18-44, and 23.6 percent of pregnant women, thought they might be depressed (Table V-12). Of those, 32.1 percent of nonpregnant women reported being diagnosed with depression, and 0 percent of pregnant women reported being diagnosed. Although the numbers of pregnant women were small in this study, 17 percent sought help from family or friends and 9 percent from a therapist or counselor for any mental or emotional problems, yet none were diagnosed with depression (IDHW, 2003b).

While it is not entirely clear what the lack of pregnant women in the study experiencing depression who were diagnosed means, the finding does indicate the importance of exploring further the mental health needs of pregnant women given that approximately 10 percent of women will experience depression during the prenatal period. It is important to intervene during pregnancy to help avoid the debilitating, long-lasting negative effects of postpartum depression, which can impact adversely the woman, her partner, and their newborn.

Other interesting findings from this study include that of the women diagnosed with depression, 96.1 percent received treatment, with the vast majority of them (68.8 percent) being treated by the family doctor. A psychologist or psychiatrist treated 20 percent of those diagnosed, and only 11 percent received treatment from mental health centers, groups, religious counselors, or family or friends (IDHW, 2003b). It is unknown whether some women received treatment from multiple providers. The course of treatment the family doctor provides, including whether medication is combined with talk therapy and/or referrals to community resources, is not known, nor is the comfort level of these providers in addressing the mental health issues of their patients. Of the 6.1 percent of women who needed treatment but didn't receive it, the most stated reason was financial or that insurance didn't cover the associated costs.

Table V-12.
Mental Health Among Idaho Women of Childbearing Age, 2001

In the past year, the respondent:	Population	Percent	Confidence		N
Sought help from family or friends for any mental or emotional problems	Women, 18-44	29.4	26.3	32.5	1,275
	Pregnant Women	17.0	4.7	29.2	77
Sought help from a therapist, counselor, or self-help group for any mental or emotional problems	Women, 18-44	15.1	12.7	17.5	1,275
	Pregnant Women	9.0	0.0	19.8	77
Thought she may have depression	Women, 18-44	37.2	34.0	40.5	1,272
	Pregnant Women	23.6	10.3	37.0	77
Was diagnosed with depression *among those who thought they may have depression*	Women, 18-44	32.1	27.0	37.1	474
	Pregnant Women	0			
Received treatment for depression *among women who were diagnosed with depression within the last year*	Women, 18-44	96.1	92.9	99.3	160
	Pregnant Women	0			
Had this person treat the depression *among women who received treatment for depression within the last year*	Psychologist or Psychiatrist	20.2	12.3	28.1	152
	Family Doctor	68.8	59.9	77.8	152
	Other*	11.0	5.0	16.9	152
Needed treatment for any mental or emotional problems during the last 5 years but was unable to get it	Women, 18-44	6.1	4.5	7.7	1,273
Had this reason for inability to get treatment for her mental or emotional problem	Cost Too Much or Insurance Didn't Cover	86.1	79.1	94.1	76
	Embarrassed or Stigmatized	4.8	0.0	9.7	76
Attempted suicide within the last year	Women, 18-44	1.0	0.0	1.9	1,273

*The Other category includes Mental Health Center, Self-Help groups, family or friends, and religious counselors.
Source: IDHW 2003b

The Division of Health is also utilizing the PRATS surveillance system to explore the prevalence of postpartum depression. The survey is completed via mail by women approximately 3-12 months after the delivery of their baby. Sixty point nine (60.9) percent of Idaho resident adult mothers reported being at least a little depressed during the 3 months after the delivery of their new baby (IDHW, 2005a).

Given the stigma of depression, especially among new mothers, the Division of Health supplemented the standard depression question in the PRATS survey with the Postpartum Depression Screening Scale (PDSS) Short Form. The PDSS consists of seven questions to assess degree of symptoms of postpartum depression. This scale was included in the 2002 Hispanic PRATS and the 2003 PRATS (which provides statewide and district-level estimates).

Results from the 2002 PRATS study indicated that 63.1 percent of non-Hispanic mothers and 79.4 percent of Hispanic mothers had significant symptoms of postpartum depression (PRATS PPD Special Report). Furthermore, 2.5 percent of non-Hispanic mothers and 4.8 percent of Hispanic mothers indicated that they either agreed or strongly agreed with the statement, "I have thought that death seemed like the only way out of this living nightmare" (Idaho Department of Health and Welfare, 2004d).

Analysis of the 2002 Hispanic PRATS indicates that women were at higher risk for symptoms of postpartum depression if they had one or more of the following characteristics:

- Low income
- Unintended pregnancy
- LBW baby
- Low education attainment for age
- Not married at time of delivery

PRATS data also showed that a higher proportion of women have significant symptoms of postpartum depression at 12-15 weeks postpartum and then again at 32-35 weeks postpartum.

Similarly, the findings of the Latino focus groups commissioned by the Idaho Primary Care Association echoed the PRATS and BRFSS data. As described by one health provider, "There is a lot of need for emotional assistance to deal with Latina women's stress, domestic violence, abuse, and fighting." Mental health issues reported by the focus group respondents included depression, stress, domestic violence, ETOD abuse, and "Nervios" (Spanish term for anxiety). The literature cites that Latinos, particularly migrant farm workers, experience high levels of stress, anxiety related to employment, and lack of social support. All contribute to the above problems (Hovey, 2002).

Almost 40 percent (164) of the Family Health Survey respondents stated they needed help for feeling depressed or nervous during pregnancy. Of those, about 27 percent never sought help; 50

percent sought help and found it useful; and 17 percent couldn't find help or, once they found it, did not find it useful.

- ***Mental Health Capacity***

The Adult Mental Health Services Program in the Idaho Department of Health and Welfare focuses its efforts on individuals who have SPMI. In addition, they will serve any individual 18 years of age or older who is experiencing an acute psychiatric crisis, including suicidal and/or homicidal behavior, and who may end up in an inpatient psychiatric facility if mental health intervention is not provided promptly. Only short-term treatment or intervention, not to exceed 120 days, is provided to this population.

For those with SPMI, the following core mental health services are provided: (1) Screening, (2) Targeted Case Management, (3) Crisis Intervention, (4) Psychiatric Rehabilitation, (5) Assertive Community Treatment, (6) Psychiatric Services, and (7) Short-term Mental Health Intervention.

For FY 2004, 10,684 clients were enrolled in services and 7,586 were "unenrolled" (Mental Health Program, 2004). If the estimates cited (approximately 25,000 individuals with SPMI) are accurate reflections of the needs of the population, the Department of Health and Welfare is serving approximately 68 percent of the eligible population. Data are not available on clients served by race or ethnicity or the comprehensiveness of the services provided.

For the population not receiving services through Idaho's Adult Mental Health Services, there is a shortage of mental health professionals and mental health services. Every county in Idaho is deemed a Mental Health Professional Shortage Area. In 2000, there were 580 psychologists in the State (Department of Health and Human Services [DHHS], 2004).

Other preventive mental health services include postpartum depression support groups that are often provided through the larger hospitals, and Parents as Teachers (PAT). While PAT's primary goal is parent-child interaction and school readiness, it has an additional mental health promotion component.

Screening for psychosocial risk factors by physicians and other types of providers is an important tool for early intervention in management of mental health problems. Idaho does not have in place guidelines for mental health screening and no protocol for the coordinated response to an identified mental health problem. The availability of training and support for primary health care providers in screening and treating mental health issues is an important topic that deserves further exploration.

l. Alcohol, Tobacco, and Other Drugs

The negative health consequences associated with smoking, alcohol, and other drug use are well documented. The use of these substances by women in Idaho and the availability of intervention services are the focus of this section.

- ***Cigarette Smoking***

Nationally, the percentage of women who smoke, a behavior associated with numerous chronic illnesses, has remained steady over the last several years at slightly more than 20 percent of women aged 18 and older (Brett, 2002). In Idaho in 2003, 25.9 percent of females aged 18-24 reported smoking cigarettes within the past month. In this age group, slightly more females than males reported smoking in the past month (25.9 versus 23.8 percent). However, women ages 25-34 were less likely than men to have smoked in the previous month. For both sexes combined, cigarette smoking was most prevalent among adults aged 25-34 (23.8 percent) and 35-44 (26.2 percent) and decreased with increasing age to 8.5 percent of individuals aged 65 and older (IDHW, 2004b).

Maternal smoking during pregnancy is associated with ectopic pregnancies, miscarriages, LBW, and infant mortality. There was a decrease from 1999 to 2001 in the proportion of mothers who reported cigarette smoking during the 3 months prior to becoming pregnant from 23.6 percent in 1999 to 19.7 percent in 2001. Non-Hispanic White women were more than twice as likely to smoke during pregnancy as Hispanic women (10.2 versus 4.6 percent) (IDHW, 2005a).

Idaho birth records indicate much lower rates for smoking during pregnancy than when women were asked 3-12 months postpartum. Risk-specific data is often underreported on the birth certificate; nevertheless, the data does reflect variation among Regions. Only 9 percent of mothers in Region 3 reported smoking during pregnancy in comparison to 20 percent of mothers in Region 1 (State of Idaho Substance Abuse Social Indicators, 2003).

Table V-13.
Percent of Live Births with Tobacco Use as a Risk Factor During Pregnancy, 3-year Average, 2001-2003

	Total Live Births	Number of Births Where Mother Reports Tobacco Use	% of Births Where Mother Reports Tobacco Use
Region 1	2,276	446	20
Region 2	1,126	169	15
Region 3	3,049	379	11
Region 4	5,469	477	9
Region 5	2,581	342	13
Region 6	2,713	285	11
Region 7	2,738	274	10
State Total	19,954	2,373	12

Source: State of Idaho Substance Abuse Social Indicators

Rather than examining the prevalence of smoking during pregnancy, the Family Health Survey focused on the respondents' perceptions and behaviors about seeking help to stop smoking. The survey revealed that 15 percent of respondents reported needing help during pregnancy to quit smoking. Of those, 18 percent did not seek help, 15 percent sought help but did not find it useful, and 51 percent found useful help.

- ***Alcohol Misuse***

In 2003, 7 percent of females and 24.7 percent of males aged 18 and older reported binge alcohol use in the previous month, defined as having 5 or more drinks on the same occasion at least once in the month prior to the survey. Additionally, 1.4 percent of females and 9.4 percent of males aged 18 and older reported heavy alcohol use in the past month, defined as having 5 or more drinks on the same occasion on 5 or more days within the month prior to the survey (IDHW, 2004b).

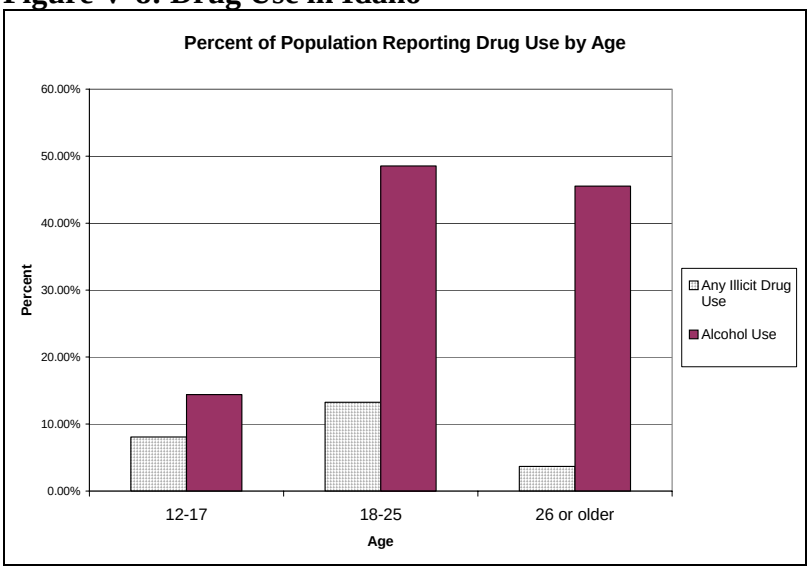
Alcohol misuse appears higher among young adult women than among their older counterparts. Among women 18-24 years old in 2003, 13.6 percent reported heavy drinking in the past month. Females in other age groups reported lower rates of binge drinking. After age 25, binge alcohol consumption declined significantly for both males and females. For heavy drinking, no significant differences among female age groups were reported. Among women aged 15-44, there did not appear to be differences among Hispanic and non-Hispanics. More data are needed to explore these behaviors among other racial and ethnic groups in Idaho (IDHW, 2004b).

Drinking alcohol during pregnancy contributes to Fetal Alcohol Syndrome (FAS), LBW, and developmental delays in children. There is little data in Idaho that provides a description of the prevalence of alcohol use during pregnancy. Birth certificate data is one avenue, however it is probably underreported. The State 3-year average (2001-2003) was 0.73 percent, with a high of 1.43 percent in Region 1 and a low of 0.40 percent in Region 4 (State of Idaho Substance Abuse Social Indicators, 2004).

- ***Illicit Drug Use***

Because of the potential risk for misuse and addiction, marijuana or hashish, cocaine, inhalants, hallucinogens, heroin, and prescription-type psychotherapeutic drugs used for nonmedical purposes are classified as illicit drugs in the United States. In Idaho in 2003, 10.9 percent of women aged 18-25 had used some type of illicit drug within the past year. There did not appear to be differences in use among Hispanic and non-Hispanic women.

Figure V-8: Drug Use in Idaho



Note: Percent using in last 30 days
Source: State of Idaho Substance Abuse Social Indicators, (Analysis of National Household Survey on Drug Abuse, 2003)

In a survey of law enforcement, judges, probation officers, prosecutors, and public defenders within each county, 97.1 percent of respondents felt that methamphetamine use was one of the most harmful drugs in their area (Idaho State Police, 2003a). The number of methamphetamine laboratories seized per year per county shows that there are heavy pockets of activity. In Kootenai County, there were 107 labs seized between January 2000 and January 2004.

- ***Drug and Alcohol Prevention and Treatment***

The Department of Health and Welfare has a well-developed, regionalized drug and alcohol prevention system. Each region conducts a yearly Prevention Needs Assessment and develops corresponding priorities. Through a State-sponsored Web site, providers can access resources on community needs, develop services based on best and promising practices, and measure effectiveness through outcome evaluations and other research tools. Furthermore, the annual Idaho Prevention Conference brings together service providers and policy makers to learn about innovative strategies including specific sessions on alcohol and drug prevention.

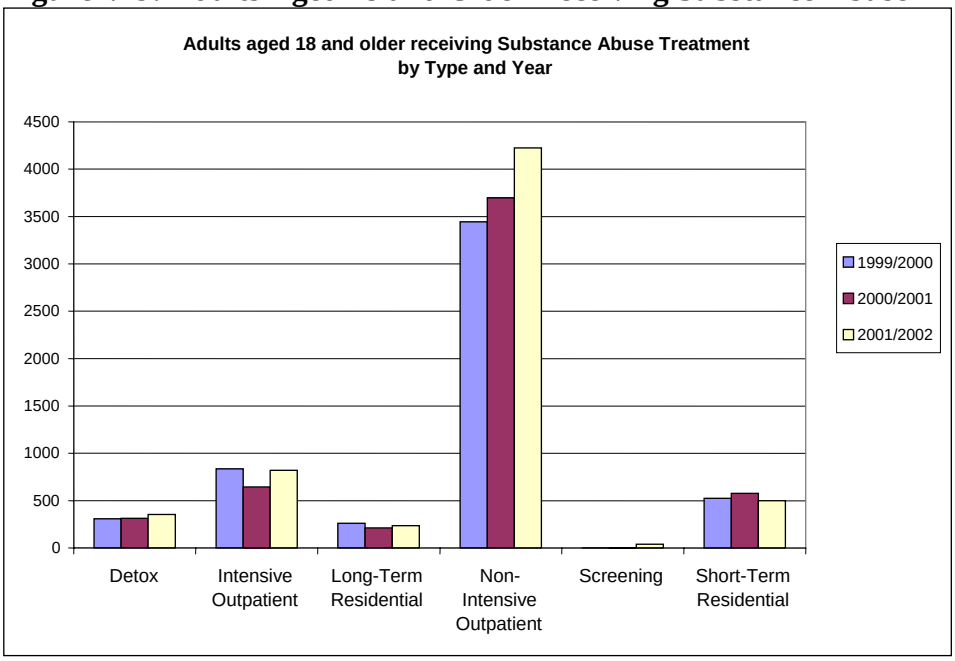
From 1999-2002, the Department of Health and Welfare served approximately 5,200 adult clients per year in Public Treatment Programs. For State FY 2003, the rate per 1,000 adults ranged from 1.9 in Region 4 to 4.5 in Region 2 (Table V-14). The majority of the clients received nonintensive outpatient followed by intensive outpatient care (Figure V-9). Alcohol was listed as the primary drug of abuse, followed by methamphetamines and then marijuana.

As reported by the Idaho Department of Health and Welfare, methamphetamine addiction in adult and adolescent populations continues to rise in the state. Sixteen (16) percent of adult clients reported methamphetamine as their primary drug choice in 1997. This use steadily increased to 23 percent in 2000, with an alarming 34 percent adult usage in 2004 (State of Idaho Substance Abuse Social Indicators, 2004).

Table V-14. Idaho State Rate per 1,000 Adults in Idaho by Region				
	State Fiscal Year			
Region:	**99/00**	**00/01**	**01/02**	**02/03**
Region 1	4.2	3.8	3.7	4.0
Region 2	3.8	4.0	3.9	4.5
Region 3	5.8	5.0	4.4	3.8
Region 4	2.5	2.3	2.5	1.9
Region 5	2.6	3.0	3.9	3.5
Region 6	3.0	3.2	3.7	3.5
Region 7	4.1	4.1	5.1	4.0

Source: State of Idaho Substance Abuse Social Indicators, 2004

Figure V-9: Adults Aged 18 and Older Receiving Substance Abuse Treatment



Source: State of Idaho Substance Abuse Social Indicators, http://www.class.uidaho.edu/sasi (analysis of IDHW Client Information System)

It is critical that providers identify chemically dependent pregnant women and a support system is in place for her to detoxify and stay clean. The impact of substance abuse on the developing fetus, and a woman's ability to parent, is well documented. Key informants indicated that although there is an emphasis on treatment for pregnant women, few services are actually available.

As the table below describes, there are nine facilities in Idaho that specifically served pregnant or postpartum women. All nine provided outpatient services, two provided partial hospitalization or

day treatment, and only one provided residential treatment. Of the nine, two had a sliding fee scale and only one offered payment assistance.

Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, yet this type of treatment is difficult to find in many communities. In Idaho, of the nine facilities for pregnant women, only three provided a mix of mental health and substance abuse services. Two of the three were located in Idaho Falls.

Table V-15.
Substance Abuse Facilities for Women and Pregnant Women in Idaho

	Women	Pregnant/ Postpartum Women
Substance Abuse Services	25	9
Substance Abuse - Mental Health Services	8	3
Type of Care		
Outpatient	23	9
Partial Hospitalization or Day Treatment	5	2
Residential Short-term Treatment (30 Days or Less)	4	1
Residential Long-term Treatment (More than 30 Days)	4	1
Hospital Inpatient	0	0
Forms of Payment Accepted		
Medicaid	9	2
Sliding Scale	11	2
Payment Assistance	3	1

Source: SAMHSA, 2005.

It should be noted that Medicaid does not reimburse for inpatient mental health or substance abuse treatment.

m. Violence Against Women

Violent crimes include rape, sexual assault, robbery, and aggravated and simple assault.

Violent crimes are perpetrated by strangers, friends, acquaintances, other relatives, or intimate partners. Women are more likely to be the victims of violent acts committed by intimate partners.

The majority of sexual assaults and rapes also occur among women. In 2001, respondents to the Idaho Crime Victimization Survey reported more sexual assaults and rapes than in 2000. Rates increased 39.2 percent in 2000 (from 8.4 to 11.7 per 1000 households) and 91.6 percent in 2001 (from 11.7 to 22.4 per 1000 households). The survey also revealed that 77.1 percent of sexual assault and rape incidents and 54.1 percent of nonsexual assault incidents were not reported to police (Stohn, 2003).

According to the survey, the rate for crimes of domestic violence decreased 38.6 percent from 43.0 per 1,000 persons 18 or older in 2000 to 26.4 per 1,000 persons 18 or older in 2001. Children were present in 52.5 percent of domestic violence incidents. Survey respondents also indicated that 59.7 percent of domestic violence incidents were not reported to the police. Reasons for not reporting domestic violence were:

- It is a private matter (48.6 percent)
- Police would do nothing (17.1 percent)
- Abuse would get worse (2.9 percent)
- Combination of other reasons (31.4 percent) (Stohr, 2003).

According to police report data, which only contain information about crimes reported to the police not all perpetrated crime in Idaho, there were 36,693 documented incidents of domestic violence from 1995 to 2001, 79.5 percent of which were committed against women. Age patterns for intimate partner violence peaked between the ages of 25-34 years (Idaho State Police, 2003b).

- ***Domestic Violence in Pregnancy***

In 2001, women who were 3-12 months postpartum were asked if anyone pushed, hit, slapped, kicked, choked, or physically hurt them during the 12 months before they got pregnant and during their most recent pregnancy. One (1) in 15 mothers (6.5 percent) reported that they were physically abused during the 12-month period before pregnancy. Nearly 1 in 20 mothers (4.2 percent) reported that they were physically abused during pregnancy (IDHW, 2005a).

The risk of physical abuse during the 12-month period before pregnancy was higher for specific groups (IDHW, 2005a):

- ***Young Women.*** Idaho resident mothers 18 to 24 years of age (11.8 percent) compared with mothers 25 years of age and older (5.7 percent).
- ***Women with Low Education Attainment.*** The risk of physical abuse during the 12-month period before pregnancy was higher for Idaho resident adult mothers with low or average education attainment for age (9.4 and 9.1 percent, respectively) than for mothers with high education attainment for age (4.0 percent).
- ***Unmarried Women.*** The risk of physical abuse during the 12-month period before pregnancy was higher for women who were not married (19.6 percent) than for married women (3.8 percent).

Service providers often feel uncomfortable screening for domestic violence because they do not know how to ask about it and are often unprepared to deal with clients' responses. Just over one-third of Idaho resident adult mothers who received prenatal care (37.1 percent) were given information about physical abuse to women by their husband or partner by a doctor, nurse, or

other health care provider (IDHW, 2005a). It would be useful if health care institutions, agencies, and private practices had guidelines for screening, patient education, response processes, and referrals.

n. Other Health Issues

Idaho has one of the lowest rates of female death due to cancer and heart disease in the country. It is one of the few States in which women have already met the Healthy People 2010 target for reducing deaths due to colorectal cancer. It is also ranks high in terms of physical activity. However, Idaho ranks as one of the lowest States in the Nation in the percentage of women receiving cholesterol screenings, routine checkups, or regular mammograms and pap smears (Brett, 2004).

- ***Diabetes***

While there are many other health topics and concerns for women, diabetes requires special note. Diabetes is a chronic condition and a leading cause of death and disability in the United States. Complications from diabetes include loss of vision, kidney failure, heart disease, limb amputations, and nerve damage, conditions which can both shorten the life span and diminish the quality of life.

In 2003, the prevalence of adult diabetes was 6.3 percent, having increased by 50 percent since 1994. Females aged 65 and older were more likely to have been diagnosed with diabetes (12.7 percent), and the percentage having been diagnosed with diabetes increased with each age group (IDHW, 2004b). In Idaho, death rates due to diabetes based on a 3-year average (2000-2002) were twice as high for Hispanics when compared to non-Hispanics and non-Whites compared to Whites (Idaho Diabetes Prevention and Control Program, 2004).

The report, *Health Care Access Barriers for Idaho Latinos,* echoed this finding, saying, "Diagnosis of Diabetes is a death sentence" (Hakes, 2003). The report goes on to note that diabetes is a serious problem in the State and more resources are needed to raise awareness about prevention and treatment among the Latino community.

Diabetes is also a problem in the Native American community with the disease reaching epidemic proportions. Nationally, 14.5 percent of the population receiving care from Indian Health Services (IHS) has diabetes (American Diabetes Association, 2005). Several Idaho tribes have implemented obesity prevention and diabetes control programs.

At the State level, the Idaho Diabetes Prevention and Control Program works to increase the awareness of individuals and providers about the prevention and treatment of diabetes. The program produced educational materials in both Spanish and English and has also established the Diabetes Alliance of Idaho. This Alliance created a directory of providers offering specific diabetes services. There is a diabetes specialist in each of the DHOs to offer support and education.

2. *Outcome: Pregnant women use early and adequate prenatal care.*

For women to receive quality prenatal services, they must have easy access to a system of comprehensive, coordinated health services. The case study of the South Central DHO provides an example of the struggles to create a comprehensive, coordinated system of quality prenatal care.

The South Central DHO serves pregnant women through the WIC Program, family planning clinic, and smoking cessation classes and provides pregnancy testing and referrals for prenatal care clients. Staff recognize the need for other community services, such as prenatal and parenting classes, but the community lacks the resources to provide them

The South Central District has the second lowest rate of first trimester prenatal care in the State (74 versus 82 percent). This is most likely due to the lack of providers who accept Medicaid. Other physicians, it is believed by the District Director, will not provide services until Medicaid eligibility has been determined. At one time, the WIC program used to screen for Medicaid "pre-eligibility" but found it did not expedite the process for Medicaid enrollment. Now they give brochures and refer those who appear to be eligible to the Department of Health and Welfare.

While the District staff has attempted to engage physicians in forums to discuss this issue, physicians do not attend them. Additionally, the local labor and delivery hospital has shown no interest in addressing this problem. The District would like to conduct a local assessment to truly understand the barriers to care and develop a plan to address them, but they lack the resources to do so.

The South Central DHO is not unique in its frustration related to a lack of a system of care for families. From each stakeholder's perspective, there are perceived barriers to getting needed services. There are hospital staff that are looking for ways to engage women in prenatal classes, there are Medicaid staff who are working hard to expedite PWC eligibility, there are families who are being denied early prenatal care services, and there are doctors who are overloaded and cannot find the psychosocial services their patients need.

This section examines many of these issues in more detail.

a. First-trimester Prenatal Care

The percent of Idaho births where prenatal care was initiated in the first trimester was comparable to the national average, 81.7 percent in Idaho versus 83.7 percent in the United States (see table below). This overall comparison masks the differences by race, ethnicity, and age. The rate for the non-Hispanic White population in Idaho is slightly lower than the rate for the non-Hispanic White population in the United States. The same holds true for the Hispanic population across each age category. Because Idaho has a predominantly White population, the lower rates for other races and ethnicities have less effect on the overall rate in Idaho. There are also significant entry-to-prenatal-care differences among health districts, with the range being from 71.8 percent in District 1 to 88.8 percent in District 4.

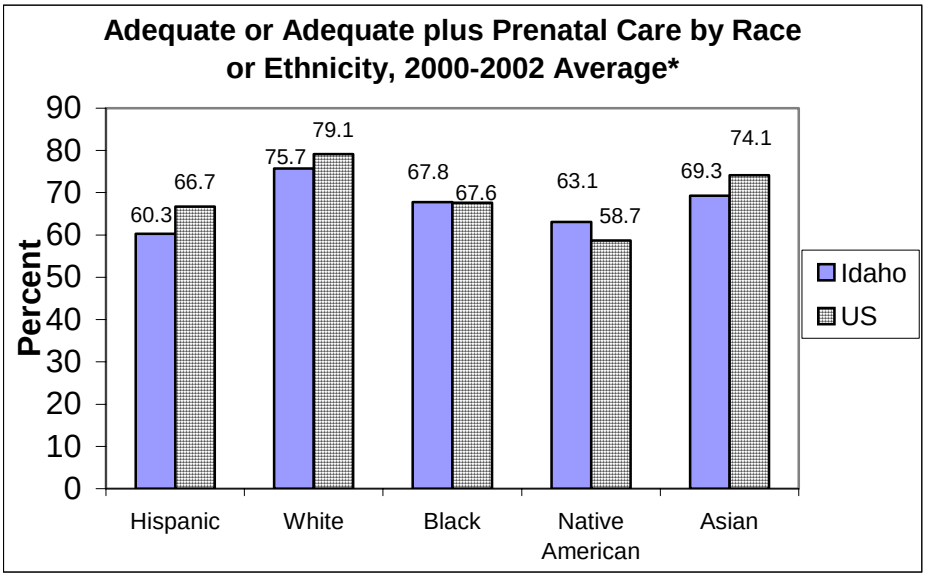
Table V-16. Proportion of Women Who Initiated Prenatal Care in the First Trimester			
Source	**Idaho Vital Statistics (2002)**	**Idaho Vital Statistics (2001-2003)**	**U.S. Vital Statistics (2002)**
ALL	**82.1**	**81.7**	**83.7**
Race			
White	82.5	82.1	85.4
Black	82.7	83.7	75.2
American Indian	71.0	69.4	69.8
Asian or Pacific Islander	83.5	82.7	84.8
Ethnicity			
Hispanic	70.2	69.3	76.7
Districts			
District 1	71.8		
District 2	86.0		
District 3	77.4		
District 4	88.8		
District 5	74.2		
District 6	84.2		
District 7	86.1		
Ages			
<15		45.5	48.2
15-19		64.7	70.0
20-24		79.8	78.6
25-29		85.3	86.3
30-34		86.6	89.8
35-39		80.0	89.2
40+		77.8	86.3

Source: IDHW, 2004c, and National Center for Health Statistics

b. Adequacy of Prenatal Care

The adequacy of prenatal care by race or ethnicity reflects data for first trimester care, namely, that within each race or ethnicity category Idaho is lower than the national average for Hispanics, Whites, and Asians, yet higher for Native Americans.

Figure V-10: Adequate or Adequate Plus Prenatal Care by Race or Ethnicity, 2000-2002 Average



*Adequacy is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into one of four categories (inadequate, intermediate, adequate, and adequate plus) by combining information about the timing of prenatal care, the number of visits, and the infant's gestational age.
Source: March of Dimes, www.marchofdimes.com/peristats (analysis of National Center for Health Statistics, final natality data)

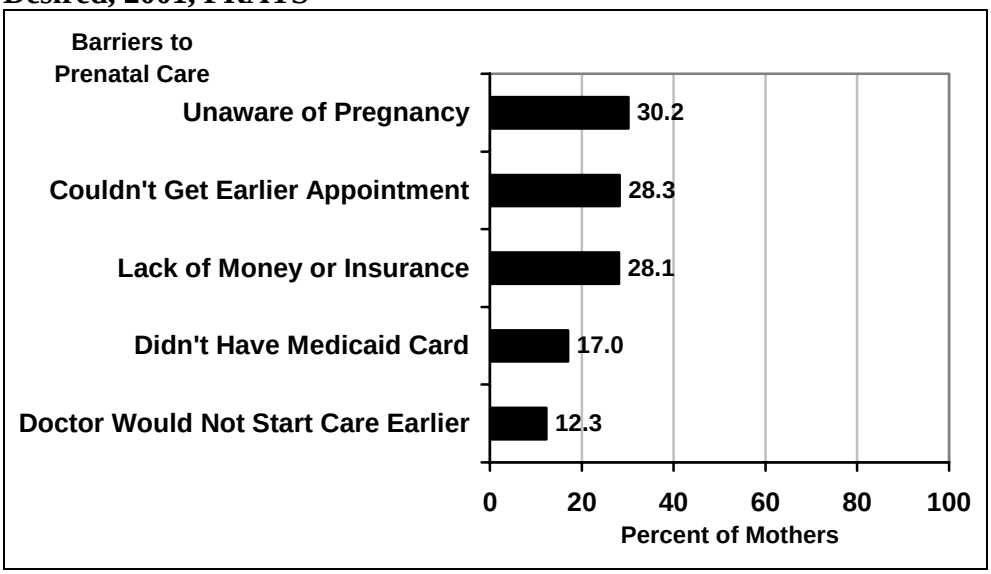
Key-informant interviewees and focus group participants identified a variety of barriers to accessing early and adequate prenatal care. First, the distances that need to be traveled and the lack of transportation, particularly in rural areas, to obtain care are prohibitive. Second, many women lack insurance and do not have the money to pay for associated out-of-pocket expenses. Third, key informants questioned if women valued prenatal care particularly after the first pregnancy or if some women only seek care when they are ill.

Most Idaho Family Survey respondents either did not need help finding prenatal care (57 percent) or found such help to be useful (39 percent). Very few respondents described looking but not being able to find prenatal care. While it was not possible to assess whether they received early and adequate prenatal care using objective measures, respondents clearly did not perceive finding care as a serious concern. Interestingly, however, 238 out of the 359 respondents (66 percent) stated they needed help paying for prenatal care. Of those, 188 respondents (79 percent) were able to find payment help, and 9 percent needed help but did not seek it.

While many service providers in Idaho question whether pregnant women value prenatal care, in 2001, mothers self-reported that the issue is more about access than values. Results indicate that 80.8 percent of Idaho resident adult mothers received prenatal care as early in their pregnancy as they wanted. Of those who were able to access care when they desired, 95 percent were able to do so in the first trimester. Of the 19.2 percent of mothers who did not receive prenatal care as early in their pregnancy as desired, 66.3 percent actually did receive care in the first trimester. If there was a question of valuing care, we would perhaps see a smaller percent of mothers receiving care early (IDHW, 2005a).

Instead, PRATS data suggests that women do not receive services as early as they desire because they were unaware of the pregnancy (30.2 percent), were not able to obtain an appointment earlier (28.3 percent), lacked money or insurance (28.1 percent), did not have a Medicaid card (17.0 percent) or the doctor would not start care earlier (12.3 percent) (IDHW, 2005a) (see graph below).

Figure V-11: Reasons Cited that Kept Women from Getting Prenatal Care as Early as Desired, 2001, PRATS



c. Quality of Prenatal Care

Traditional quality measures for obstetrics include the week of pregnancy at which the mother entered prenatal care and the baby's birth weight, Apgar scores, and gestational age at birth. However, those measures do not evaluate how effectively a system addresses issues such as poverty, dysfunctional family environments, smoking and substance abuse—all of which can have a negative impact on pregnancy. The rest of this section examines the management of high-risk pregnancies and what system is in place to meet the physical and psychosocial needs of high-risk pregnant women.

- ***Identifying and Serving High-risk Pregnancies***

All hospital and prenatal staff interviewed as key informants indicated that they screened for medically high-risk pregnancies and for the high-risk women identified trying to arrange for the delivery to occur in a hospital with a neonatal intensive care unit. There does not appear, however, to be a statewide system of transfer or referrals in place from Level I nurseries to Levels II and III.

Providers in small rural hospitals experience particular problems in dealing with high-risk pregnancies. They are often required to work in multiple departments of the local hospital and

report being "stretched too thin." There are very few OB/GYNs in the rural communities, and most physicians are general practitioners with hospital delivery privileges.

Although routine high-risk medical screening and referrals are reportedly conducted, no one interviewed for the assessment could identify a specific high-risk screening tool that is promoted or used. As described earlier, the Central DHO is the only provider identified during this assessment as providing intensive prenatal services. Each woman receives a comprehensive risk-reduction assessment and the appropriate followup education or counseling services. On the DHO's own initiative, they are looking at ways to identify pregnant women based on risk factors, and triage them to an appropriate level of care. Their goal is to create a high-risk identification process so they can be most efficient with their limited resources and better provide patient-centered care. Some providers described the lack of services for socially high-risk pregnant women as a particular problem. Most did not feel they knew of any resources in the community that could provide additional supports or services the women may need.

While Idaho Medicaid's policy is to identify high-risk births among recipients and arrange for them to have additional prenatal visits and extra monitoring, most direct service providers interviewed did not know of this Medicaid initiative or the potential additional visits for such women. Interestingly, even the Central DHO was not aware that there was a specific category of services available for high-risk pregnant women via Medicaid.

Since pregnant women with HIV are considered high-risk, it is important to describe the process of identification of these women. The State of Idaho follows CDC guidelines that recommend universal counseling and voluntary HIV testing of all pregnant women. There is no specific law or regulation regarding testing for mothers and newborns. In 2001, approximately half (49.0 percent) of Idaho resident adult mothers indicated that they were tested for HIV during their pregnancy. One (1) in 6 mothers (16.1 percent) was unsure whether she had been tested for HIV. Nearly one in three mothers (35.0 percent) indicated that she had not been tested for HIV (IDHW, 2005a).

- ***Cultural Competency***

For a health system to be effective, patients must feel that providers respect their culture and language and recognize the context and complexity of their lives.

While many think of cultural competency in terms of language, race, or ethnicity, Idaho has a somewhat different set of circumstances that need to be understood and embraced. In Idaho, there is a growing number of Hispanics and a small but strong Native American community. There are also families that choose to live in frontier counties. Many are fiercely independent and wary of government intervention. There also are many families where religion and spirituality have a profound importance and are significant sources of health and well-being.

There are both protective practices and potentially harmful practices among different cultures, and it is the health provider's role to acknowledge all of the varying cultural healing practices,

even if they are not understood, and come to mutually acceptable and understandable interventions for care.

In the needs assessment's focus group, the overwhelming majority of Hispanic mothers rated the prenatal care they received as very poor. They shared accounts of being left for hours in the examination room and of not being told they had a high-risk pregnancy but later finding out it was in their medical charts. One woman reported that a doctor performed a C-section earlier than the due date because he had to go on vacation early.

A hospital-based childbirth educator described how PAT trained Latina women to be peer mentors and how this initiative has been very successful in increasing knowledge about healthy behaviors and parenting in culturally acceptable ways. She thought the same type of peer counseling should be implemented during pregnancy.

Providers also explained that many women seek the services of a midwife. They choose this partly because of cost and partly because they want their birth to be less "medicalized." With very few opportunities to use the services of a certified nurse-midwife (CNM), many women opt for direct-entry or lay midwives, some of whom are certified while others are not. Two rural hospitals indicated that the presence of CNMs on staff would be an enormous benefit to families enabling them to reach out to families and assure safe birth practices that met their cultural needs. One urban provider described hoping to develop partnerships with birthing centers so women would be more likely to seek prenatal care.

The desire of some women to use the services of a midwife provides an example of Idaho's challenge in supporting culturally competent care. The medical community is grappling with how to regulate and interact with direct-entry midwives. There are reports that when midwives bring a failed home birth to the hospital, they are often treated poorly by staff and blamed for the medical emergency. This treatment, rather than encouraging a partnership, discourages midwives from coming to the hospital. Some hospitals, on the other hand, are trying to bring direct-entry midwives into their circle of care through supervision and training embracing nonjudgmental attitudes.

Deciding the best course of action requires a better understanding of why people are choosing home births and how women and providers can come to mutually acceptable health practices.

- ***Service Coordination***

Most focus group participants reported receiving early and adequate prenatal care and also felt that the information they received from their health provider was useful. There were some critical exceptions, however, to the positive experiences reported. For example, women who obtained prenatal care in a clinic setting saw different providers for each visit, interfering with continuity of care. This made it difficult to establish a relationship with a provider and ensure that the provider was fully aware of the woman's status.

An area for further exploration is the referral mechanism and information sharing between the family planning clinic and prenatal care providers. Many women learn they are pregnant at the family planning clinic. Family planning data indicates that 62.1 percent of the pregnant women who come to the family planning clinic had an unplanned pregnancy. For such women, the family planning clinic may be the first point of entry into the health care system and moving them on to a prenatal provider is essential. Given that the family planning clinic conducts a full health assessment, with the women's consent the resulting information could be provided to the prenatal provider to better assure continuity and quality of care.

Interestingly, the Central DHO has created this referral mechanism with one group of obstetrical providers. When a woman comes to the family planning clinic for a pregnancy test and the pregnancy confirmed, staff assist her in applying for Medicaid's PWC and conduct a risk reduction assessment. Once she prequalifies for Medicaid, the DHO helps arrange the first prenatal visit with an obstetrician. Importantly, the DHO is trying to develop a system that will link the postpartum mother back into the family planning clinic after her 60-day postpartum eligibility ends. They see this as a critical piece of continuing care for her and helping assure that the next pregnancy is planned.

Another potential opportunity is coordination between WIC and prenatal care providers. Approximately 34 percent of women participated in WIC during their pregnancy. In particular, WIC seems to be effective in reaching the Hispanic population, with 62.1 percent of Hispanic mothers reported having participated in WIC during pregnancy. Furthermore, thirty (30) percent of WIC participants enrolled during their first trimester of pregnancy. Given that a large proportion of Hispanic women, in particular, are not receiving adequate prenatal care, WIC may be a vital gateway into the health system.

Exploring the coordination and referral mechanisms between WIC and Medicaid provides insight into some of the system coordination issues that are typical to the State system of care. It should be noted that Idaho is not unique in these system issues. Nevertheless, the WIC-Medicaid example is illustrative of system barriers.

The WIC Procedure Manual states that referrals must be provided to every participant. Referrals include Medicaid, food stamps, SCHIP, immunizations, drugs and other harmful substances, and other referrals as needed. The WIC data system captures referrals made to Medicaid or other programs, but there is no mechanism in place to conduct followup to the referrals in the system. It is left to the discretion of each WIC clinic to develop a procedure for referral followup. Most of the followup is on an ad hoc basis and not necessarily documented. Health providers are given information only on a case by case basis, and information is not routinely shared. If information is shared, it is usually about the special feeding needs of a child.

There is not a designated person or central liaison in WIC or Medicaid. When WIC staff have questions regarding Medicaid eligibility, they often get passed around from person to person at Medicaid. Furthermore, Medicaid staff are very busy and often do not have time to answer WIC-related questions. WIC staff, for their part, are unfamiliar with the scope of services provided

through Medicaid and how the Healthy Connections program works. From WIC's perspective, Medicaid staff are unaware of the scope of WIC services.

WIC believes that joint training, where local level staff from both Medicaid and WIC learn about one another's programs, would go a long way in helping both to recognize and pursue opportunities for coordination.

3. Outcome: Pregnant women use as appropriate the full range of enabling and support services to promote a positive pregnancy outcome.

a. Prenatal Classes

Prenatal and childbirth classes are primarily offered in urban areas. For the most part, classes are taught by certified childbirth educators in urban areas. In the rural areas, where there are fewer health providers, the availability of classes is much more variable and classes that do exist are usually taught by labor and delivery nurses rather than certified childbirth educators.

Both rural and urban key informants report that it is very difficult to engage pregnant women in childbirth classes. In the rural areas, women usually have to travel far to participate, although urban hospitals report a similar lack of participation in childbirth classes. They hypothesize that pregnant women perceive the birthing classes to focus primarily on pain management, and because they are opting for an epidural at birth, they do not see the value of the classes. Further study needs to be conducted to understand better what type of information expectant parents want and how best to provide it.

A little over half of the Family Health Survey respondents described needing and receiving information on what to expect regarding pregnancy and childbirth, advice on healthy eating, and what to do when the baby arrives. Most who sought information found it helpful. Only about 5 percent of families found the information unhelpful.

b. WIC

WIC is implemented by 9 agencies, with over 60 clinic sites. In 2003, WIC served 64,438 clients, 19,111 which were pregnant women or mothers. The majority of participants (75 percent) had family income levels 130 percent or less of the federal poverty guidelines.

Table V-17.
WIC Family Income Levels, 2003

Income Levels	Number of Families	Percent
0-130%	18,419	75
131-150%	2,302	9
151-185%	3,645	15
Total	23,066	100

Source: Idaho WIC, 2002.

Participants in the focus groups conducted as part of this assessment who were enrolled in WIC reported satisfaction with the services. They received useful nutrition and breastfeeding information and necessary subsidies. Interestingly, the Hispanic focus group participants had a somewhat different perspective about WIC. They received important information on breastfeeding and nutrition, yet many of them had lived in other States before coming to Idaho and reported that while other State WIC programs provide classes on child development and parenting, Idaho WIC is limited to nutrition education. They described how in California, WIC assesses for child development delays and if a problem or issue is identified, extra developmental services are provided. They saw this as a very important service that was lacking in Idaho.

c. Early Head Start

Just 2 percent of eligible pregnant women were enrolled in Idaho's Early Head Start compared to the national average of 12 percent (Idaho Head Start Association, 2004). Although fewer pregnant women in Idaho were enrolled in Early Head Start than women across the United States, they fared better in Idaho's programs. They were more likely to receive all four main prenatal services, especially mental health and substance abuse services. This increased utilization of services is especially critical considering that a greater proportion of Idaho's pregnant women were "medically high risk" than the United States (Table V-18).

Table V-18: Selected Characteristics of Pregnant Women Enrolled in Early Head Start During the 2002-2003 Program Year

Characteristics	Idaho	U.S.
Enrollment	1.7%	12%
Under 18 years of age	20.3%	24%
With health insurance	86.4%	85%
Pregnancies defined as "medically high risk"	32.2%	24%
Received the following services:		
Prenatal and postpartum care	100%	94%
Mental health and substance abuse interventions and followup	61.0%	28%
Prenatal education on fetal development	98.3%	92%
Information of benefits of breastfeeding	98.3%	93%
Received dental exams	37.3%	No data

Sources: Idaho data is from the Idaho Head Start Association, 2004, and national data is from CLASP, 2004.

Summary Findings and Analysis

Women of childbearing age use ongoing preventive and primary care appropriately.

Summary

- Approximately one in three women in Idaho reported lack of health insurance prior to pregnancy.
- Many women lack access to comprehensive, affordable health care before, during, and after pregnancy. Many women who hold private insurance have high deductibles that make care too expensive. For those on Medicaid, pregnancy-related services are narrowly defined and not universally understood.
- There is confusion around eligibility and scope of services provided under Medicaid for Pregnant Women and Children.
- In comparison to the United States average, Idaho has been successful in reaching its population in need of Title X services. In the United States, approximately 40 percent of the women in need of public services received them, while Idaho served 50 percent of the target population. There were variations in planned pregnancies among age and ethnicity.
- Data strongly suggest that racial and ethnic discrepancies exist in Idaho in terms of diagnosing breast cancers early among younger women (aged less than approximately 55).
- There are a substantial number of women who report feeling depressed or have symptoms of depression but are not being diagnosed or treated. Those that have been diagnosed are being treated by their family physician.
- Two-thirds of pregnant women did not have dental care during their pregnancy, nor do they report being told by their prenatal providers about the importance of getting regular dental care.
- In Idaho, death rates due to diabetes based on a 3- year average (2000-2002) were twice as high for Hispanics compared to non-Hispanics and for non-Whites compared to Whites. Diabetes has reached epidemic proportions among Native Americans.

Analysis

- The continuum of mental health services is severely lacking. Screening at the physician's office is variable, there are few services that women are using that promote their emotional well-being, and there is a shortage of mental health professionals.
- Lack of affordable and quality health coverage is creating difficulties in accessing care.
- There are many potential opportunities through initiatives like Any-Door and the CareLine that, when optimized, could make a big difference in family's lives.

Pregnant women use early and adequate prenatal care.

Summary

- The percent of Idaho births where prenatal care was initiated in the first trimester was comparable to the national average. This overall comparison masks the differences by race, ethnicity, age, and region. The rate for the non-Hispanic White population in Idaho is slightly lower than the rate for the non-Hispanic White population in the United States.
- Data suggest that women did not receive services as early as they desired because they were unaware of the pregnancy, were not able to receive an appointment earlier, lacked money or insurance, did not have a Medicaid card, or found that the doctor would not start care earlier.
- All hospital and prenatal staff key informants indicated that they screen for medically high-risk pregnancies and, for those identified, try to arrange delivery in a hospital with a neonatal intensive care unit. There is no apparent statewide system of transfer or referrals.

Analysis

- There is no universal or systematic high-risk prenatal identification system. Providers are not given training or guidelines; therefore, screening may vary by site and/or provider.
- Midwifery care is variable, and most midwives do not have strong ties to the medical community. Both of these issues raise the risk of inappropriate care for high-risk pregnancies.
- There is no systematic approach that provides comprehensive and coordinated health and enabling services based on a particular pregnant woman's need.
- While some providers respect, and are sensitive to a woman's culture and language and recognize the context and complexity of women's lives, there is evidence that some providers do not.

Pregnant women use as appropriate the full range of enabling and support services to promote a positive pregnancy outcome.

Summary

- Few mental health and other psychosocial services in Idaho appear to specifically target pregnant women and new mothers.
- Focus group participants indicated variable access to classes and support groups.
- WIC is very successful in reaching and serving pregnant women.

Analysis

- There is not a system in place that screens women for psychosocial and environmental risk factors during and after pregnancy and refers them to appropriate services.
- Prenatal and parenting classes and parenting support groups are not available are not equally integrated into local resources in all communities. There is an opportunity to offer these classes and groups through local hospitals and community-based programs like WIC.

MOTHERS

Introduction

Much of what constitutes ongoing primary care has been touched on in the previous section. Women should receive regular breast and cervical cancer screening, have access to and utilize family planning and dental care, and take care of themselves by eating healthy and exercising regularly. Moreover, they should have access to the critical services necessary to prevent and treat violence in the home, substance abuse, and mental health issues.

This section of the report contains a closer look at postpartum care. Women and newborns must stay in the hospital for a sufficient amount of time to ensure the stable health status of both of them. Followup care for the mother should normally include a physician visit at 6 weeks postpartum. During that visit a medical exam should be conducted as well as screening for postpartum depression and discussion of and services for family planning goals. The visit and followup care should assess how the mother is adapting to parenting by observing parent-infant attachment and whether she has developmentally appropriate expectations.

Characteristics of Mothers

- ***Marital Status.*** Because the marital status of a mother can affect her economic well-being and ability to meet the full range of needs of her infant, it is useful to review this data. While the number of Idaho resident out-of-wedlock births has increased each year since 1998, the percent of total live births that were out-of-wedlock births decreased slightly from 22.0 in 2001 to 21.9 in 2002 (IDHW, 2004). It is important to note that Idaho has a predominately White population and therefore the actual numbers of these births to other racial and ethnic groups is relatively small.

Table V-19.
Idaho Out-of-wedlock Births by Race and Ethnicity

	2002	2001	2000
Total	21.9%	22.0%	21.6%
White	21.2	21.4	20.9
Black	33.0	40.5	46.7
Am. Indian	54.0	56.9	60.0
Asian/Pacific Islander	13.8	11.6	15.9
Ethnicity: Hispanic*	36.1	34.1	33.1

*Race and Hispanic origin are reported separately on the birth certificate. Women of Hispanic origin are included in appropriate race totals.
Source: IDHW, 2000, 2001, 2004a

- ***Maternal Age.*** Between 1991 and 2003, the U.S. birth rate for teens aged 15-19 declined to 43.0 births per 1,000 teen girls in 2002, after reaching its highest point in two decades (61.8 births per 1,000 teen girls aged 15-19 in 1991). Idaho ranks

24th among the States with a 2002 teen birth rate of 39.1 (National Campaign to Prevent Teen Pregnancy, 2004). The following table displays the teen births by race or ethnicity and by age of mother for the average of years 2001-2003.

Table V-20.
Idaho Resident Teen Live Births
Number and Rate of Live Births by Race, Ethnicity, and Age, 2001-2003

	AGE							
	<15		**15-19**		15-17		18-19	
RACE / ETHNICITY	Number	Rate	**Number**	**Rate**	Number	Rate	Number	Rate
U.S. Total		**0.7**		**43.0**		**23.2**		**72.8**
Idaho Total	56	0.4	**6,362**	**39.8**	1,731	18.3	4,631	71.2
Race								
White	52	0.4	**5,955**	**38.9**	1,616	17.8	4,339	69.7
Black	-	-	**40**	**33.2**	11	17.9	29	49.1
American Indian	2	0.6	**200**	**63.4**	60	31.7	140	110.8
Asian or Pacific Islander	-	-	**66**	**29.5**	15	11.2	51	56.9
Other Race	-	N/A	**3**	**N/A**	1	N/A	2	N/A
Race Not Stated	2	N/A	**98**	**N/A**	28	N/A	70	N/A
Ethnicity								
Hispanic	29	1.6	**1,503**	**93.7**	552	58.2	951	144.7

Teen Birth Rate: Number of births in specified age group per 1,000 females in corresponding age group (based on July 1, 2002 bridged race population estimates released August 8, 2003).
Source: IDHW, 2004c.

Births to White teens were recorded at 38.9 (6,362 births) in average of 2001-2003, with births to Hispanic teens at 93.7 (1,503 births) and to American Indian teens at 63.4. Information about teen birth rates is important as these young women may be at risk for a number of health and social problems and often need extra support in caring for an infant.

- ***Mother's Level of Education.*** Also of interest is the mother's level of education, because of its association with pregnancy outcomes.

Approximately half of Idaho births were to mothers with some college education or higher (49 percent). Only 15 percent of Idaho mothers had less than a high-school degree; however, there was wide variation among districts, with 27 percent in District 5 and 10 percent in District 4 (IDHW, 2004a). In Idaho, low educational attainment is linked to unintended pregnancy, risk of physical abuse, smoking during pregnancy, and breastfeeding rates (IDHW, 2005a).

Table V-21. Percent of Idaho Births by Mother's Education, 2002						
		<High School	High-School Graduate	Some College	Bachelor's Degree or Higher	Not Stated
Idaho	**20,973**	**15%**	**32%**	**29%**	**20%**	**3%**
District 1	2,226	12%	40%	27%	18%	3%
District 2	1,189	11%	31%	30%	28%	0%
District 3	3,715	22%	34%	23%	13%	8%
District 4	5,563	10%	27%	30%	30%	3%
District 5	2,550	27%	29%	26%	15%	3%
District 6	2,789	13%	40%	28%	17%	2%
District 7	2,941	13%	29%	43%	15%	1%

Source: IDHW, 2004a

Given this demographic context, the rest of the chapter explores mothers' access to postpartum health and enabling services and breastfeeding rates.

Idaho Health Outcomes for Mothers

Three outcomes have been selected for in-depth examination for the Idaho maternal population. Achieving these outcomes will help to ensure that women and the families they care for are healthy.

Table V-22. Idaho Mothers Outcomes
Mothers use comprehensive postpartum services and ongoing primary care.
Mothers use as appropriate the enabling and support services needed by them and their families to care for their infants and children.
Mothers have access to breastfeeding information and support as needed.

1. Mothers use comprehensive postpartum services and ongoing primary care.

The American Academy of Pediatrics has recommended specific criteria for newborn discharge; and in most instances, it is unlikely that fulfillment of these criteria and conditions can be accomplished in less than 48 hours (AAP, 2004). If discharge is considered before 48 hours, it should be limited to infants who are of singleton birth between 38 and 42 weeks' gestation, who are of birth weight appropriate for gestational age, and who meet other specific discharge criteria. Given that hospital-specific discharge data is not analyzed by the State, nor are there State-level protocol or regulations on hospital stay, hospital policies and procedures and whether those procedures are being followed are unknown. It is also unknown whether some hospitals are discharging patients earlier than other hospitals.

The American Academy of Pediatrics and American College of Obstetrics and Gynecology recommend that, prior to discharge, the mother be informed of normal postpartum events,

including the changes in the lochial pattern that she should expect in the first few weeks; the range of activities that she may reasonably undertake; the care of the breasts, perineum, and bladder; dietary needs, particularly if she is breastfeeding; the recommended amount of exercise; emotional responses; and observations that she should report to the physician (e.g., temperature elevation, chills, leg pains, or increased vaginal bleeding).

According to self-reported 2001 PRATS data, 75 percent of Idaho resident adult mothers spent less than 48 hours in the hospital or birthing center after childbirth. Fifty-nine (59) percent spent one to two days, while 16 percent spent less than 24 hours. Similarly, most babies (55.6 percent) spent 1-2 days in the hospital or birthing center after birth. More babies spent 4 or more days in the hospital or birthing center (12.9 percent) than mothers (8.4 percent) (IDHW, 2005a).

Most focus group participants stated that they received no information from the hospital about what to expect after delivery. Those that did receive information stated it was through brochures given by the hospital. Two mothers received special training, such as baby CPR, which they found very useful. The same mothers received follow up telephone calls from providers.

Generally, Hispanic focus group participants recounted tales of bad experiences during delivery:

- One woman described how she went to the hospital in labor and her physician asked her to go home and return later when she was closer to delivery. Instead, she ended up giving birth shortly thereafter and he sent her home the same day.
- Another woman reported that a friend of hers was also sent home the same day as delivery.
- Another woman was told she would have to wait until the next scheduled meal before receiving food and water after her delivery.
- Another woman was not given an epidural even though she asked for one 6 hours in advance of delivery.

All Hispanic participants agreed that deliveries tended to go smoother if patients were fluent in English.

After delivery, only two focus group participants received a home visit, one from the Prenatal Ancillary Care (PAC) Program for low-income mothers and one from the Infant-Toddler Program. Both mothers were very satisfied with the timeliness and usefulness of the home visit. Many other mothers noted they would have liked to receive a home visit, particularly for those who had perinatal or birth complications. Some even specifically requested breastfeeding education from the birth hospital but did not receive it. Fortunately, both Hispanic and non-Hispanic mothers seemed to have a more positive experience in WIC, receiving both breastfeeding support and information about caring for their infant.

Little information is available to assess the number of women receiving postpartum care and the quality of that care. One recent study surveyed Idaho hospitals and learned that 9 out of the 35

had existing programs or were developing postpartum depression support groups (IDHW, 2005c).

There were no reported maternal deaths in 2001 or 2002. In 2000, two deaths were reported, but their causes were not reported. The State does not regularly assess or report maternal illness and complications due to pregnancy.

2. Mothers use as appropriate the enabling and support services needed by them and their families to care for their infants and children.

As described earlier, many parents rely on WIC for nutritional education and support. Some focus group participants in this needs assessment reported that WIC will also hold classes on the days mothers come in to receive their food vouchers. The Idaho Department of Health and Welfare has developed a series of informational brochures for women in the perinatal period. The brochure *After You Deliver: Health Tips for Moms* includes information on nutrition, breastfeeding, and immunizations. There are also brochures on perinatal substance abuse, SIDS, WIC, and benefits of folic acid, among other topics.

Families also should have access to health and parenting education. Such education could include recognizing signs of stress and learning appropriate coping mechanisms; developing appropriate expectations; and supporting healthy communication skills and healthy relationships, including decisionmaking, negotiation skills, and parenting discipline. Parenting support is explored further in the Infant section of this report.

Focus group participants described receiving services through the Family Service Alliance, which offers help to victims of domestic violence and other at-risk parents and PAT. Only one participant received home visits through PAT; generally, participants felt that there were not enough parenting classes available for the general community. They expressed a desire for parent support groups, especially for first-time mothers and parents of CSHCN.

3. Mothers have access to breastfeeding information and support as needed.

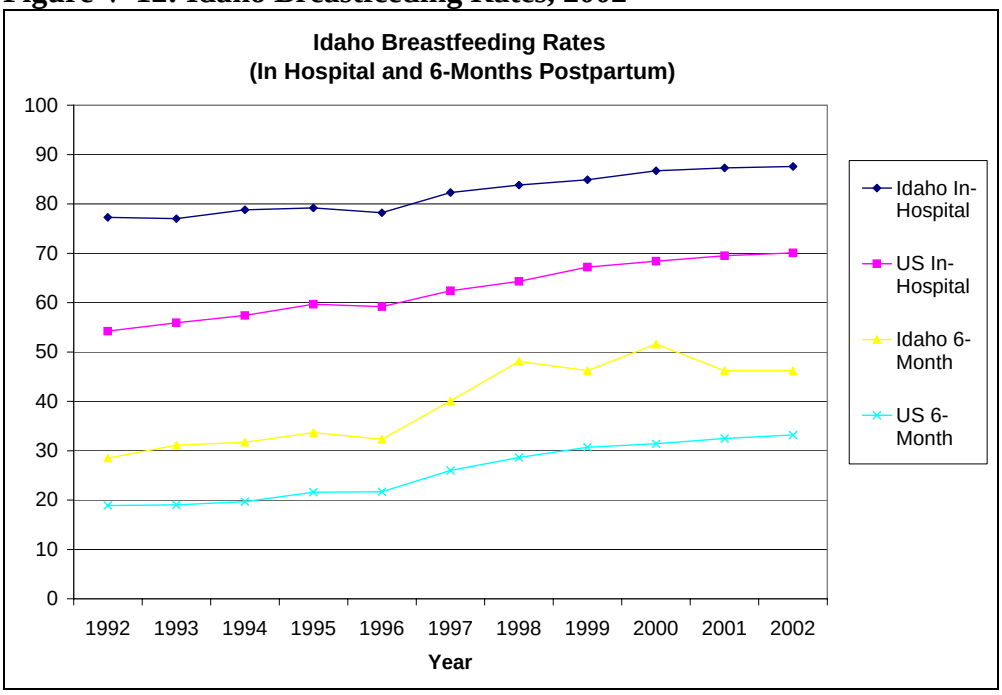
Breastfeeding Initiation and Duration

New breastfeeding data collected as part of CDC's 2003 National Immunization Survey (NIS), indicated that only six states, including Idaho, met all of the Healthy People 2010 objectives for breastfeeding. Across these six states, 75 percent of mothers initiated breastfeeding in the hospital and 50 percent maintained breastfeeding at 6 months postpartum (National Immunization Program, 2003).

The Ross Mothers Survey (an ongoing mail survey periodically sent to a nationally representative sample of new mothers), provides data specifically for Idaho. According to the 2002 Survey, the proportion of Idaho mothers initiating breastfeeding has been nearly 20 percent higher than the national average and the proportion continuing breastfeeding at 6 months post partum has been nearly 10 percent higher (Figure V-12). In fact, 87.6 percent of Idaho mothers

initiated breastfeeding at the hospital and 46.2 percent were breastfeeding at 6 months postpartum, meeting the 2010 goals for initiation and almost meeting the goal for duration in 2002 (Ross Products Division, 2003).

Figure V-12: Idaho Breastfeeding Rates, 2002



Source: Ross Products Division, 2003

Assessing the percent of women who only fed their infant breastmilk and water—no solids or other liquids—describes a somewhat different story. While Idaho was still much higher than the national average, in 2002, 55.7 percent (±6.0 percent) of women reported exclusively breastfeeding at 3 months and 23.9 percent (±5.3 percent) at 6 months (National Immunization Program, 2003).

Idaho WIC participants are also more likely to breastfeed than WIC participants at the national level. In 2002, Ross data indicated that 83.7 percent of Idaho WIC participants initiated breastfeeding in comparison to 58.2 percent nationwide. Similarly, 35.5 percent of Idaho WIC participants were breastfeeding at 6 months postpartum, compared to 20.8 percent nationwide.

Data from the Idaho WIC program in 2001 indicates similar rates; and with program data, we are also able to look at regional variation. The South Central region reported the lowest initiation rates at 70 percent, and North Central was the highest at 85 percent. Interestingly, the North Central region experienced the largest decrease, with only 25 percent breastfeeding at 6 months.

Table V-23.							
	Initiation	**One Month**	**Two Months**	**Three Months**	**Four Months**	**Five Months**	**Six Months**
Statewide	**79**	**66**	**51**	**44**	**39**	**36**	**32**
Panhandle	80	68	55	45	43	40	36
North Central	85	69	51	43	36	32	25
Southwest	78	63	50	47	41	36	33
Central	81	68	52	47	41	40	38
South Central	70	58	45	37	30	28	24
Southeastern	76	64	51	45	38	34	31
District 7	83	71	53	44	44	40	34

Source: Idaho WIC Program, 2002

In 2001, PRATS data indicates an even higher breastfeeding rate than the Ross data, with 89.2 percent of Idaho adult mothers reporting they ever breastfed their baby. Women were more likely to initiate breastfeeding if they had high educational attainment for age, high household income, or were married. Women were also more likely to initiate breastfeeding with their first child, but women with more than 1 child were slightly more likely to continue breastfeeding at 6 months postpartum. While maternal employment had little impact on breastfeeding initiation, women who were employed full time are less likely to breastfeed 6 months after the birth of their child than women who were not employed or working part time (IDHW, 2005a).

A variety of reasons for discontinuing breastfeeding were given by PRATS respondents. The most common were not having enough milk (32.5 percent) and breast milk alone not satisfying their baby (29.1 percent). Other reasons include nipple or breast problems (13.3 percent), inconvenience to continue (13.0 percent), and needing someone else to feed the baby (10.1 percent), among others (IDHW, 2005a).

- ***Access to Lactation Support Services***

Lactation support services, for the most part, are available through WIC, La Leche, and hospital classes.

Focus group participants indicated they had access to lactation specialists who were very helpful, many of whom were available on call. One issue reported was that most insurers do not cover breastfeeding pump costs. One provider whose patients often receive services across the border in Washington described how she regularly uses the Washington Healthy Mothers Healthy Babies Web site for breastfeeding resources and support. She suggested that the Idaho Department of Health create a similar accessible and useful site.

Idaho Health Outcomes for Mothers

Mothers use comprehensive postpartum services and ongoing primary care.

Summary

- Data is not available to examine whether women obtain postpartum visits.
- Seventy-five (75) percent of Idaho resident adult mothers spent less than 48 hours in the hospital or birthing center after childbirth. Fifty-nine (59) percent spent 1-2 days, while 16 percent spent less than 24 hours.
- Women want information on what to expect, breastfeeding support, and parenting issues, and many are unable to access them.
- No system is in place that identifies pregnancy-related morbidity and mortality trends and responds accordingly.

Analysis

- There is a need for data on the use of postpartum care
- There is a need to emphasize the value of postpartum care and its ability to link women to needed community and preventive services.

Mothers use as appropriate the enabling and support services needed by them and their families to care for their infants and children.

Summary

See Infant Section

Analysis

Mothers have access to breastfeeding information and support as needed.

Summary

- The percentage of Idaho mothers initiating and continuing at 6 months postpartum is higher than the national average. In 2002, 87.6 percent of Idaho mothers initiated breastfeeding at the hospital, and 46.2 percent were breastfeeding at 6 months postpartum, meeting the 2010 goals for initiation and almost meeting the goal for duration.
- Idaho WIC participants are also more likely to breastfeed than WIC participants at the national level.
- Most health insurance companies do not cover breast pumps.

Analysis

- While breastfeeding rates are high, reasons given for not continuing could be addressed with additional lactation support.